

Student Health Exam Forms 2018-19

Ninth Grade and Transfer Students

A healthcare provider must complete, sign, and stamp the Child and Adolescent Health Examination Form that follows below.

A healthcare provider must complete, sign, and stamp the following **Medication Administration Form(s) (MAF)** if your daughter has **asthma**, **anaphylaxis allergies**, **diabetes**, or needs to **self-administer any type of medication**. Once a healthcare provider has completed these forms, a parent must also sign them.

<u>Immunization Requirements</u>: <u>Documentation</u> of **2 doses of varicella vaccine**, **1 dose of meningococcal vaccine**, and **4 doses of polio vaccine**, unless 3rd dose was received at 4 years of age or older.

All 12th Grade Students

<u>Immunization Requirements:</u> <u>Documentation</u> of **2 doses of meningococcal vaccine** with the booster dose given on or after age 16 or 1 dose if your child's first dose was given on or after age 16.

For more information regarding immunizations, please review the **New York State Immunization and Medical Requirements**.

2018-2019 Central/Yeshiva University High School for Girls

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CHILD & ADOLESCENT HE NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE			RM Please Print Clearly Press Hard	STUDENT ID N	NUMBER OSIS			
TO BE COMPLETED BY PARENT OR GUARDIAN								
Child's Last Name	First Name	First Name Midd				Birth (Month/Day/Year)		
Child's Address Hispanic/Latino? Race (Check ALL that apply) American Indian Asian Black White								
City/Borough S	tate Zip Code	School/Center/Camp N	np Name		District			
Health insurance ☐ Yes ☐ Parent/Guardian Last N ☐ Foster Parent	ame	First Name			Cell			
TO BE COMPLETED BY HEALTH CARE PROVIDER If "yes" to any item, please explain (attach addendum, if needed)								
Birth history (age 0-6 yrs) Does the child/adolescent have a past or present medical history of the following?								
☐ Uncomplicated ☐ Premature: weeks gestation	Asthma (check severity	☐ Asthma (check severity and attach MAF/Asthma Action Plan): ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent						
Complicated by	ir persistent, check all current medication(s):							
, ,	☐ Attention Deficit Hype☐ Chronic or recurrent or		□ Orthopedic injury/disab□ Seizure disorder	ility	Medications (attach MAF if in-school medication needed)			
Allergies	☐ Congenital or acquire		□ Seizure disorder □ Speech, hearing, or visit □ Speech, hearing, hea	ual impairment	☐ None ☐ Yes (list l	below)		
☐ Drugs (list)	Developmental/learnir		Tuberculosis (latent infec	ction or disease)				
☐ Foods (list)	☐ Diabetes (attach MAF)	☐ Diabetes (attach MAF) ☐ Other (specify) ☐ Dietary Restrictions						
Other (list)	_	Explain all checked it	tems above or on adden	dum	□ None □ Yes (list below)			
PHYSICAL EXAMINATION	General Appe	•						
Heightcm (_	%ile) NI Abnl	NI Abni	NI Abni	NI Abni	NI Abni			
Weightkg (_	HEE	' '				nosocial Development		
BMI kg/m² (—		Genitou	,	Neurological	-		
	Describe above							
Head Circumference (age ≤2 yrs) cm (_	%ile) Describe abno							
Blood Pressure (age ≥3 yrs) / /	-			1				
DEVELOPMENTAL (age 0-6 yrs) ☐ Within normal limits	SCREENING TESTS	Date Done	Results		Date Done	Results		
If delay suspected, specify below	Blood Lead Level (BLL)	//	μg/dL	Tuberculosis	Only required for students entering into who have not previously attended any	ermediate/middle/junior or high school NYC public or private school		
☐ Cognitive (e.g., play skills)	(required at age 1 yr and 2 yrs and for those at risk)	//	μg/dL					
	Lead Risk Assessment		☐ At risk (do BLL)	PPD/Mantoux place				
☐ Communication/Language	(annually, age 6 mo-6 yrs)	/	1	PPD/Mantoux read	d//	. □ Neg □ Pos		
	Hearing			Interferon Test	//	☐ Neg ☐ Pos		
☐ Social/Emotional	☐ Pure tone audiometry☐ OAE	//	☐ Normal Chest x-ray			□ NI □ Not □ Abnl Indicated		
☐ Adaptive/Self-Help	_	Head Start Only -	(If PPD or		//	- April Illulcateu		
	Hemoglobin or		g/dL	Vision		Acuity Right /		
☐ Motor	Hematocrit (age 9–12 mo)	//	_	(required for new school and children age 4–7 y		Left / Strabismus \square No \square Yes		
IMMUNIZATIONS – DATES CIR Number			nfluenza					
of Child								
Rotavirus / /		// MMR // Modelia			//	//		
DTP/DTaP/DT / /			rd Td					
			Гdар / /		Hep A / /	'		
Hib / / / / /	1 1		Meningococcal	//				
PCV//////	/ /	_	HPV					
Polio//	//		Other, <i>specify:</i>					
RECOMMENDATIONS Full physical activity Full diet ASSESSMENT				Child (V20.2)	Diagnoses/Problems (list)	ICD-9 Code		
□ Restrictions (specify)								
Follow-up Needed No Yes, for	Annt date:							
		□ Vision -						
Other	ar Education							
Health Care Provider Signature			Date Dohmh PROVIDER I.D.					
Health Care Provider Name and Degree (print) Provider Lice			se No. and State TYPE OF EXAM: NAE Current NAE Prior Year(s) Comments			rent NAE Prior Year(s)		
Facility Name National Provider Identifier (NPI)								
Address City State Zip					Date I.D. NUMBER Reviewed:			
Telephone Fax					//L			