

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please
Print Clearly
Press Hard

STUDENT ID NUMBER
OSIS

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TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name	First Name	Middle Name	Sex <input type="radio"/> Female <input type="radio"/> Male	Date of Birth (Month/Day/Year) / 2008	
Child's Address			Hispanic/Latino? <input type="radio"/> Yes <input type="radio"/> No	Race (Check ALL that apply) <input type="radio"/> American Indian <input type="radio"/> Asian <input type="radio"/> Black <input type="radio"/> White <input type="radio"/> Native Hawaiian/Pacific Islander <input type="radio"/> Other	
City/Borough	State N.Y.	Zip Code	School/Center/Camp Name	District Number	Phone Numbers Home Cell Work
Health insurance (including Medicaid)? <input type="radio"/> Yes <input type="radio"/> No	Parent/Guardian Last Name	First Name			
<input type="radio"/> Parent/Guardian <input type="radio"/> Foster Parent					

TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

Birth history (age 0-6 yrs) <input type="radio"/> Uncomplicated <input type="radio"/> Premature: _____ weeks gestation <input type="radio"/> Complicated by _____ Allergies <input type="radio"/> None <input type="radio"/> Epi pen prescribed <input type="radio"/> Drugs (list) _____ <input type="radio"/> Foods (list) _____ <input type="radio"/> Other (list) _____	Does the child/adolescent have a past or present medical history of the following? <input type="radio"/> Asthma (check severity and attach MAF/Asthma Action Plan): <input type="radio"/> Intermittent <input type="radio"/> Mild Persistent <input type="radio"/> Moderate Persistent <input type="radio"/> Severe Persistent <i>If persistent, check all current medication(s):</i> <input type="radio"/> Inhaled corticosteroid <input type="radio"/> Other controller <input type="radio"/> Quick relief med <input type="radio"/> Oral steroid <input type="radio"/> None <input type="radio"/> Attention Deficit Hyperactivity Disorder <input type="radio"/> Orthopedic injury/disability <input type="radio"/> Chronic or recurrent otitis media <input type="radio"/> Seizure disorder <input type="radio"/> Congenital or acquired heart disorder <input type="radio"/> Speech, hearing, or visual impairment <input type="radio"/> Developmental/learning problem <input type="radio"/> Tuberculosis (latent infection or disease) <input type="radio"/> Diabetes (attach MAF) <input type="radio"/> Other (specify) _____	Medications (attach MAF if in-school medication needed) <input type="radio"/> None <input type="radio"/> Yes (list below) _____ _____ Dietary Restrictions <input type="radio"/> None <input type="radio"/> Yes (list below) _____
<i>Explain all checked items above or on addendum</i>		

PHYSICAL EXAMINATION

Height _____ cm (_____%ile)
Weight _____ kg (_____%ile)
BMI _____ kg/m² (_____%ile)
Head Circumference (age ≤2 yrs) _____ cm (_____%ile)
Blood Pressure (age ≥3 yrs) _____ / _____

General Appearance:

<i>Nl Abnl</i>	<i>Nl Abnl</i>	<i>Nl Abnl</i>	<i>Nl Abnl</i>	<i>Nl Abnl</i>
<input type="radio"/> HEENT	<input type="radio"/> Lymph nodes	<input type="radio"/> Abdomen	<input type="radio"/> Skin	<input type="radio"/> Psychosocial Development
<input type="radio"/> Dental	<input type="radio"/> Lungs	<input type="radio"/> Genitourinary	<input type="radio"/> Neurological	<input type="radio"/> Language
<input type="radio"/> Neck	<input type="radio"/> Cardiovascular	<input type="radio"/> Extremities	<input type="radio"/> Back/spine	<input type="radio"/> Behavioral

Describe abnormalities:

DEVELOPMENTAL (age 0-6 yrs) Within normal limits

If delay suspected, specify below

Cognitive (e.g., play skills) _____

Communication/Language _____

Social/Emotional _____

Adaptive/Self-Help _____

Motor _____

SCREENING TESTS

Date Done	Results
Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)	_____/_____/_____ _____ μg/dL
Lead Risk Assessment (annually, age 6 mo-6 yrs)	_____/_____/_____ <input type="radio"/> At risk (do BLL) <input type="radio"/> Not at risk
Hearing <input type="radio"/> Pure tone audiometry <input type="radio"/> OAE	_____/_____/_____ <input type="radio"/> Normal <input type="radio"/> Abnormal
Head Start Only	
Hemoglobin or Hematocrit (age 9-12 mo)	_____/_____/_____ _____ g/dL _____ %

Tuberculosis

Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school

Date Done	Results
PPD/Mantoux placed	_____/_____/_____ Induration _____ mm
PPD/Mantoux read	_____/_____/_____ <input type="radio"/> Neg <input type="radio"/> Pos
Interferon Test	_____/_____/_____ <input type="radio"/> Neg <input type="radio"/> Pos
Chest x-ray (if PPD or Interferon positive)	_____/_____/_____ <input type="radio"/> NI <input type="radio"/> Not <input type="radio"/> Abnl <input type="radio"/> Indicated
Vision (required for new school entrants and children age 4-7 yrs)	_____/_____/_____ <input type="radio"/> with glasses Acuity Right ____ / ____ Left ____ / ____ Strabismus <input type="radio"/> No <input type="radio"/> Yes

IMMUNIZATIONS - DATES

IMMUNIZATION	CIR Number of Child
Hep B	_____
Rotavirus	_____
DTP/DTaP/DT	_____
Hib	_____
PCV	_____
Polio	_____

Influenza	_____
MMR	_____
Varicella	_____
Td	_____
Tdap	_____
Meningococcal	_____
HPV	_____
Other, specify:	_____

RECOMMENDATIONS

Full physical activity Full diet

Restrictions (specify) _____

Follow-up Needed No Yes, for _____ Appt. date: ____/____/____

Referral(s): None Early Intervention Special Education Dental Vision

Other _____

ASSESSMENT

Well Child (V20.2) Diagnoses/Problems (list) _____ ICD-9 Code _____

Health Care Provider Signature

Date ____/____/____

DOHMH PROVIDER ONLY I.D.

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Health Care Provider Name and Degree (print)

Provider License No. and State

TYPE OF EXAM: NAE Current NAE Prior Year(s)

Facility Name

National Provider Identifier (NPI)

Comments

Address

City

State

Zip

Date

I.D. NUMBER

Telephone (____) _____ - _____

Fax (____) _____ - _____

Reviewed: ____/____/____

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REVIEWER:

To the Parent/Guardian:

Federal law requires the New York City Department of Education to collect and record the ethnic identity and race of public school students. This information is used to determine funding for your school, among other things, and is kept secure and confidential.

We need your help to accomplish this task. Please respond to the ethnicity and race identification questions on the back of this page. The first question provides an opportunity for you to indicate whether your child is of Hispanic, Latino, or Spanish origin; the second question provides an opportunity for you to indicate your child's race(s). Please be sure to respond to both questions. Students identified with more than one race will be counted in the "two or more races" category. Hispanic students of all races will be counted in the Hispanic category.

The New York City Department of Education understands the sensitive nature of this process. The options provided by the federal government may not represent an accurate or complete portrayal of your family's own ethnic or race identification. We encourage you to provide responses using your best judgment. If you decline to respond to either question, federal guidelines require New York City Department of Education school staff to make an identification of your child on your behalf.

Race and ethnicity information for students is protected by the confidentiality regulations cited at the bottom of this page.

Thank you for your cooperation.

Parents and Guardians: Please complete the form on the reverse side of this page and return it to your child's school.

School staff: File the completed form in the student's Cumulative Record folder as confidential information.

Confidentiality Procedures and Regulations

The Family Educational Rights and Privacy Act (1974) and Regulations of the Chancellor A-820 prohibit unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number.

¹ Race may be considered as a factor in school enrollment only where required by court order; gender is a factor only in single-gender schools.

Residency Questionnaire

Parent/Guardian/Student:

This form is intended to address the McKinney-Vento Act 42 U.S.C. 11435, and must be completed for each student. The information you provide is confidential. Your child will not be discriminated against based upon the information provided.

Please complete the following questions regarding the student's housing in order to help determine services the student may be eligible to receive.

Note to schools/Temporary Housing Liaisons: Please assist students and families in filling out this form. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, the **student is not required to submit proof of residency** and other required documents that may be part of the registration packet.

Student Name			
Last	First	Middle	
OSIS #	Date of Birth MM/DD/YY	Gender	School
	/ / 2008		

Please identify the student's current living arrangements. Please check one box:

Check (√)	Residency Questionnaire Choice	School Use Only
		ATS Code
	Doubled-Up With another family or other person because of loss of housing or as a result of economic hardship	D
	Shelter Emergency or transitional shelter	S
	Awaiting Foster Care Placement	A
	Hotel / Motel Living in what is NOT an emergency or transitional shelter and involves payment	H
	Other Temporary Living Situation Trailer park, campground, car, park, public places, abandoned building, street, or any other inadequate living space	T
	Permanent Housing Student who is living in a fixed, regular, and adequate housing situation	P

If the student is NOT living in permanent housing, also indicate if the below applies:

		School Use Only
	Unaccompanied Youth Youth who is not in the physical custody of a parent or guardian	Enter "Y" if applicable

Parent/Guardian Name (print)

Parent/Guardian Signature

Date

Please return this form to your child's school as requested.

Note: The answer you give above will help determine what services you or your child may be eligible to receive under the McKinney-Vento Act. Students who are protected under the Act are entitled to immediate enrollment in school even if they do not have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. After the student has been enrolled, the new school must contact the last school attended to request the student's educational records, including immunization records, and Students in Temporary Housing (STH) Liaison(s) must help the student get any other necessary documents or immunizations. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services. Please refer to Chancellor's Regulation A-780.

**This form is accompanied by a one-page attachment titled,
"McKinney-Vento Homeless Assistance Act – Students in Temporary Housing Guide for Parents & Youth."**

PARENT AFFIDAVIT OF RESIDENCY

In accordance with Chancellor's Regulation A-101, if a parent is subletting an apartment or home, or if more than one family shares a living space and there is only one leaseholder or homeowner, the parent must present a notarized "Address Affidavit" signed both by the primary leaseholder as well as the parent affirming that the family is residing in this home, and must attach the lease or deed.

Section A: STUDENT INFORMATION – Please print clearly in ink

STUDENT'S LAST NAME	STUDENT'S FIRST NAME	GENDER (optional) <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
DATE OF BIRTH (MM/DD/YY) 2008	OSIS #/STUDENT'S ID # (if available)	TELEPHONE #

STUDENT'S CURRENT ADDRESS (House #, Street, Apt. #, City, State and Zip Code) N.Y.
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Section B: PARENT INFORMATION – Please print clearly in ink

PARENT/GUARDIAN'S LAST NAME	PARENT/GUARDIAN'S FIRST NAME
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PARENT/GUARDIAN'S CURRENT ADDRESS (House #, Street, Apt. #, City, State and Zip Code)

HOME PHONE	WORK PHONE	CELL PHONE	EMAIL ADDRESS
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Section C: PRIMARY RESIDENT/TENANT INFORMATION – Please print clearly in ink

PRIMARY RESIDENT/TENANT'S LAST NAME	PRIMARY RESIDENT/TENANT'S FIRST NAME
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PRIMARY RESIDENT/TENANT'S CURRENT ADDRESS (House #, Street, Apt. #, City, State and Zip Code)

HOME PHONE	WORK PHONE	CELL PHONE	EMAIL ADDRESS
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RELATIONSHIP TO PARENT	ANTICIPATED DURATION OF STAY
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To be completed by the Parent:

I, _____, the parent of _____,
(insert name and date of birth of student)

hereby affirm that I am residing with _____
(insert name)

at the following address _____
(insert address and contact number of primary leaseholder)

I understand that the New York City Department of Education has the right to conduct an Attendance Investigation to verify my residence including a visit to the home of the primary leaseholder. I also understand that registration in school is based on eligibility determined by my residence, and the Department of Education has the right to transfer students for whom falsified documentation was provided at the time of registration.

In the event that my residency changes, I agree to notify my child's school and present new proof of address.

Parent Signature: _____

STATE OF NEW YORK

SS:

COUNTY OF _____

Sworn to before me this _____ day of _____, Year _____

Notary Public

To be completed by Primary Leaseholder/Tenant:

I hereby affirm that _____
(insert name of parent and child/children)

are residing with me at _____
(insert address)

I understand that by signing this affidavit I am verifying the residence of _____
(insert names)

I also understand that the New York City Department of Education has the right to conduct an Attendance Investigation to verify the residence of the parties named in this affidavit, including a visit to my home and interviews with my neighbors. I can be contacted at the number(s) listed below should the Department of Education require further information.

Primary Leaseholder Signature: _____

STATE OF NEW YORK

SS:

COUNTY OF _____

Sworn to before me this _____ day of _____, Year _____

Notary Public

The New York City Department of Education Pre-Kindergarten Language Needs Survey

Dear Parent or Guardian,

This survey is an important piece of your pre-kindergarten enrollment package as it provides your new school with information about your family's language needs. Your assistance in answering the questions below is greatly appreciated. Please return this form to your school administrator,

_____ , and if you have questions, speak with _____ at

_____.

Thank You

PART 1. LANGUAGE NEEDS: This information will establish what language is used at home and the language of instruction requested by the family (if available).

1. Which language(s) do you speak at home? Please check (✓) all that apply:

- | | |
|---|--|
| <input type="checkbox"/> English | <input type="checkbox"/> Urdu |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> French |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Korean |
| <input type="checkbox"/> Bengali | <input type="checkbox"/> Albanian |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Punjabi |
| <input type="checkbox"/> Haitian Creole | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Russian | <input type="checkbox"/> Other, please specify _____ |

2. What language does the child **understand**?

English Other Home Language(s) :

3. What language does the child **speak**?

English Other Home Language(s) :

4. What language does the child **read**?

English Other Home Language(s) : Does not read yet

5. What language does the child **write**?

English Other Home Language(s) : Does not read yet

6. What language is spoken in the child's home or residence **most of the time**?

English Other Home Language(s) :

7. What language does the child speak with parents/guardians **most of the time**?

English Other Home Language(s) :

8. What language does the child speak with brothers, sisters, or friends **most of the time**?

English Other Home Language(s) :

9. What language does the child speak with other relatives or caregivers (e.g., babysitters) **most of the time**?

English Other Home Language(s) :

10. Would you like your child to receive instruction using your home language (if available):

All the time Most of the time Some of the time

The New York City Department of Education Pre-Kindergarten Language Needs Survey

TO BE COMPLETED BY ENROLLMENT OR SCHOOL PERSONNEL ONLY		
Date:	Name of Student:	
Borough	District:	School:
Gender:	Ethnicity Code: (form PSE):	Date of Birth:
Relationship of person providing information for survey (check one): <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Father <input type="checkbox"/> Other (specify): _____		
If an interview is conducted, in what language is it conducted?		
Is a translator/interpreter used?		
Pre-K Home Language Code		
Potential English Language Learner?		
Instruction will be provided in: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ <input type="checkbox"/> Both English and the home language of _____		



Department of
Education

Office of Communications and Media Relations
52 Chambers Street, New York, NY 10007
Tel: 212.374.5141 Fax: 212.374.5584

CONSENT TO PHOTOGRAPH, FILM, OR VIDEOTAPE A STUDENT FOR NON-PROFIT USE
(e.g. educational, public service, or health awareness purposes)

Student Name: _____ School: _____

I hereby consent to the participation in interviews, the use of quotes, and the taking of photographs, movies or video tapes of the Student named above by _____.

I also grant to _____ the right to edit, use, and reuse said products for non-profit purposes including use in print, on the internet, and all other forms of media. I also hereby release the New York City Department of Education and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above.

Signature of Parent/Guardian (if Student is under 18): _____ Date: _____

Address of Parent/Guardian: _____

OR

Signature of Student (if 18 or over): _____ Date: _____

Address of Student: _____