IMMUNIZATION & PHYSICAL EXAMINATION FORM

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | Sex ☐ Female ☐ Male | Date of Birth (Month/Day/Year) __ __ / __ __ / __ __ __ __

Child's Address | Hispanic/Latino? ☐ Yes ☐ No | Race (Check ALL that apply) ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other ____________

City/Borough | State | Zip Code | School/Center/Camp Name | District Number __ __ | Phone Numbers: Home ________ Cell ________ Work ________

Health Insurance (including Medicaid)? ☐ Yes ☐ No | ☐ Parent/Guardian ☐ Foster Parent Last Name | First Name

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

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: ________ weeks gestation

☐ Complicated by ________________

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* ________________

☐ Foods *(list)* ________________

☐ Other *(list)* ________________

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF/Asthma Action Plan):* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteroid ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*

☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ **Other** *(specify)* ________________

Explain all checked items above or on addendum

Medications ***(attach MAF if in-school medication needed)*** ☐ None ☐ Yes *(list below)*

Dietary Restrictions ☐ None ☐ Yes *(list below)*

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:

Nl	Abnl		Nl	Abnl		Nl	Abnl		Nl	Abnl		Nl	Abnl	
☐	☐	HEENT	☐	☐	Lymph nodes	☐	☐	Abdomen	☐	☐	Skin	☐	☐	Psychosocial Development
☐	☐	Dental	☐	☐	Lungs	☐	☐	Genitourinary	☐	☐	Neurological	☐	☐	Language
☐	☐	Neck	☐	☐	Cardiovascular	☐	☐	Extremities	☐	☐	Back/spine	☐	☐	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 ______ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	__/__/__	☐ At risk *(do BLL)* ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	__/__/__	☐ Normal ☐ Abnormal
— Head Start Only —		
Hemoglobin or Hematocrit *(age 9–12 mo)*	__/__/__	______ g/dL ______ %

	Date Done	Results
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__/__/__	Induration ____ mm
PPD/Mantoux *read*	__/__/__	☐ Neg ☐ Pos
Interferon Test	__/__/__	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__/__/__	☐ Nl ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	__/__/__ ☐ with glasses	Acuity *Right* __/__ *Left* __/__ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child ☐☐☐☐☐☐☐☐☐

Hep B __/__/__ __/__/__ __/__/__ __/__/__
Rotavirus __/__/__ __/__/__ __/__/__
DTP/DTaP/DT __/__/__ __/__/__ __/__/__
__/__/__ __/__/__ __/__/__
Hib __/__/__ __/__/__ __/__/__ __/__/__
PCV __/__/__ __/__/__ __/__/__ __/__/__
Polio __/__/__ __/__/__ __/__/__ __/__/__

Influenza __/__/__ __/__/__ __/__/__
MMR __/__/__ __/__/__ __/__/__
Varicella __/__/__ __/__/__ __/__/__
Td __/__/__ __/__/__ __/__/__
Tdap __/__/__ Hep A __/__/__ __/__/__
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 __/__/__

Health Care Provider Name and Degree *(print)* | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (___) ___-____ | Fax (___) ___-____

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