

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

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

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history (age 0-6 yrs) <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____ Allergies <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> Other (list) _____ Attach MAF if in-school medications needed	Does the child/adolescent have a past or present medical history of the following? <input type="checkbox"/> Asthma (check severity and attach MAF) <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent If persistent, check all current medication(s): <input type="checkbox"/> Quick Relief Medication <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Oral Steroid <input type="checkbox"/> Other Controller <input type="checkbox"/> None Asthma Control Status <input type="checkbox"/> Well-controlled <input type="checkbox"/> Poorly Controlled or Not Controlled <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Behavioral/mental health disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Hospitalization <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Surgery <input type="checkbox"/> Orthopedic injury/disability <input type="checkbox"/> Other (specify) _____ Explain all checked items above. <input type="checkbox"/> Addendum attached.	Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)
---	--	---

PHYSICAL EXAM Date of Exam: ____/____/____ Height _____ cm (____ %ile) Weight _____ kg (____ %ile) BMI _____ kg/m ² (____ %ile) Head Circumference (age ≤2 yrs) _____ cm (____ %ile) Blood Pressure (age ≥3 yrs) _____ / _____	General Appearance: <input type="checkbox"/> Physical Exam WNL <table border="0"> <tr> <td><input type="checkbox"/> Psychosocial Development</td> <td><input type="checkbox"/> HEENT</td> <td><input type="checkbox"/> Lymph nodes</td> <td><input type="checkbox"/> Abdomen</td> <td><input type="checkbox"/> Skin</td> </tr> <tr> <td><input type="checkbox"/> Language</td> <td><input type="checkbox"/> Dental</td> <td><input type="checkbox"/> Lungs</td> <td><input type="checkbox"/> Genitourinary</td> <td><input type="checkbox"/> Neurological</td> </tr> <tr> <td><input type="checkbox"/> Behavioral</td> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Cardiovascular</td> <td><input type="checkbox"/> Extremities</td> <td><input type="checkbox"/> Back/spine</td> </tr> </table>	<input type="checkbox"/> Psychosocial Development	<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Skin	<input type="checkbox"/> Language	<input type="checkbox"/> Dental	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Behavioral	<input type="checkbox"/> Neck	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Extremities	<input type="checkbox"/> Back/spine
<input type="checkbox"/> Psychosocial Development	<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Skin												
<input type="checkbox"/> Language	<input type="checkbox"/> Dental	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological												
<input type="checkbox"/> Behavioral	<input type="checkbox"/> Neck	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Extremities	<input type="checkbox"/> Back/spine												

DEVELOPMENTAL (age 0-6 yrs) Validated Screening Tool Used? _____ Date Screened ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No Screening Results: <input type="checkbox"/> WNL <input type="checkbox"/> Delay or Concern Suspected/Confirmed (specify area(s) below): <input type="checkbox"/> Cognitive/Problem Solving <input type="checkbox"/> Adaptive/Self-Help <input type="checkbox"/> Communication/Language <input type="checkbox"/> Gross Motor/Fine Motor <input type="checkbox"/> Social-Emotional or Personal-Social <input type="checkbox"/> Other Area of Concern: _____ Describe Suspected Delay or Concern: _____	Nutrition < 1 year <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula <input type="checkbox"/> Both ≥ 1 year <input type="checkbox"/> Well-balanced <input type="checkbox"/> Needs guidance <input type="checkbox"/> Counseled <input type="checkbox"/> Referred Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)	Hearing Date Done ____/____/____ Results < 4 years: gross hearing ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred OAE ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred ≥ 4 yrs: pure tone audiometry ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred
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="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk	Child Care Only Hemoglobin or Hematocrit _____ g/dL _____ %	Vision Date Done ____/____/____ Results < 3 years: Vision appears: ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl Acuity (required for new entrants and children age 3-7 years) Right ____/____/____ Left ____/____/____ <input type="checkbox"/> Unable to test Screened with Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Strabismus? <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Visible Tooth Decay <input type="checkbox"/> Yes <input type="checkbox"/> No Urgent need for dental referral (pain, swelling, infection) <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Visit within the past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No

Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No CIR Number _____ Physician Confirmed History of Varicella Infection <input type="checkbox"/>	Report only positive immunity: <table border="0"> <tr> <td>IgG Titers</td> <td>Date</td> </tr> <tr> <td>Hepatitis B</td> <td>____/____/____</td> </tr> <tr> <td>Measles</td> <td>____/____/____</td> </tr> <tr> <td>Mumps</td> <td>____/____/____</td> </tr> <tr> <td>Rubella</td> <td>____/____/____</td> </tr> <tr> <td>Varicella</td> <td>____/____/____</td> </tr> <tr> <td>Polio 1</td> <td>____/____/____</td> </tr> <tr> <td>Polio 2</td> <td>____/____/____</td> </tr> <tr> <td>Polio 3</td> <td>____/____/____</td> </tr> </table>	IgG Titers	Date	Hepatitis B	____/____/____	Measles	____/____/____	Mumps	____/____/____	Rubella	____/____/____	Varicella	____/____/____	Polio 1	____/____/____	Polio 2	____/____/____	Polio 3	____/____/____
IgG Titers	Date																		
Hepatitis B	____/____/____																		
Measles	____/____/____																		
Mumps	____/____/____																		
Rubella	____/____/____																		
Varicella	____/____/____																		
Polio 1	____/____/____																		
Polio 2	____/____/____																		
Polio 3	____/____/____																		

ASSESSMENT <input type="checkbox"/> Well Child (Z00.129) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-10 Code _____	RECOMMENDATIONS <input type="checkbox"/> Full physical activity <input type="checkbox"/> Restrictions (specify) _____ Follow-up Needed <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ Referral(s): <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> IEP <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____
--	---

Health Care Practitioner Signature _____ Date Form Completed ____/____/____	DOHMH ONLY PRACTITIONER I.D. _____
Health Care Practitioner Name and Degree (print) _____ Practitioner License No. and State _____	TYPE OF EXAM: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s) Comments: _____
Facility Name _____ National Provider Identifier (NPI) _____	Date Reviewed: ____/____/____ I.D. NUMBER _____
Address _____ City _____ State _____ Zip _____	REVIEWER: _____
Telephone _____ Fax _____ Email _____	FORM ID# _____

2020-21 School Year New York State Immunization Requirements for School Entrance/Attendance¹

NOTES:

Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td) ²	4 doses	5 doses or 4 doses if the 4th dose was received at 4 years or older or 3 doses if 7 years or older and the series was started at 1 year or older		3 doses
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap) ³		Not applicable		1 dose
Polio vaccine (IPV/OPV) ⁴	3 doses		4 doses or 3 doses if the 3rd dose was received at 4 years or older	
Measles, Mumps and Rubella vaccine (MMR) ⁵	1 dose		2 doses	
Hepatitis B vaccine ⁶	3 doses		3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years	
Varicella (Chickenpox) vaccine ⁷	1 dose		2 doses	
Meningococcal conjugate vaccine (MenACWY) ⁸		Not applicable	Grades 7, 8, 9, 10 and 11: 1 dose	2 doses or 1 dose if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib) ⁹	1 to 4 doses			Not applicable
Pneumococcal Conjugate vaccine (PCV) ¹⁰	1 to 4 doses			Not applicable

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019 and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.
2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
 - b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
 - c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.
 - d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series, if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.
3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grade 6: 10 years; minimum age for grades 7 through 12: 7 years)
 - a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
 - b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2020-2021, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grade 6; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 7 through 12.
 - c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.
4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
 - b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
 - c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
 - d. Only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016 should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016 should not be counted.
5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
 - a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
 - b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
 - c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
 - d. Rubella: At least one dose is required for all grades (prekindergarten through 12).
6. Hepatitis B vaccine
 - a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute "dose 4" for "dose 3" in these calculations).
 - b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.
7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
 - a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
 - b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.
8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grade 7: 10 years; minimum age for grades 8 through 12: 6 weeks)
 - a. One dose of meningococcal conjugate vaccine (Menactra or Menveo) is required for students entering grades 7, 8, 9, 10 and 11.
 - b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
 - c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.
9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
 - b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
 - c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
 - d. If dose 1 was received at 15 months or older, only 1 dose is required.
 - e. Hib vaccine is not required for children 5 years or older.
10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
 - b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
 - c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
 - d. If one dose of vaccine was received at 24 months or older, no further doses are required.
 - e. PCV is not required for children 5 years or older.
 - f. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: www.health.ny.gov/prevention/immunization/schools

For further information, contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

New York State Department of Health/Bureau of Immunization
health.ny.gov/immunization

Immunization Requirements for School Attendance Medical Exemption Statement for Children 0-18 Years of Age

NOTE: THIS EXEMPTION FORM APPLIES ONLY TO IMMUNIZATIONS REQUIRED FOR SCHOOL ATTENDANCE

Instructions:

1. Complete information (name, DOB etc.).
2. Indicate which vaccine(s) the medical exemption is referring to.
3. Complete contraindication/precaution information.
4. Complete date exemption ends, if applicable.
5. Complete medical provider information. Retain copy for file. Return original to facility or person requesting form.

-
1. Patient's Name _____
 2. Patient's Date of Birth _____
 3. Patient's Address _____
 4. Name of Educational Institution _____
-

Guidance for medical exemptions for vaccination can be obtained from the contraindications, indications, and precautions described in the vaccine manufacturers' package insert and by the most recent recommendations of the Advisory Committee on Immunization Practices (ACIP) available in the Centers for Disease Control and Prevention publication, Guide to Vaccine Contraindications and Precautions. This guide can be found at the following website: <http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm>.

Please indicate which vaccine(s) the medical exemption is referring to:

- | | |
|---|---|
| <input type="checkbox"/> Haemophilus Influenzae type b (Hib) | <input type="checkbox"/> Measles, Mumps, and Rubella (MMR) |
| <input type="checkbox"/> Polio (IPV or OPV) | <input type="checkbox"/> Varicella (Chickenpox) |
| <input type="checkbox"/> Hepatitis B (Hep B) | <input type="checkbox"/> Pneumococcal Conjugate Vaccine (PCV) |
| <input type="checkbox"/> Tetanus, Diphtheria, Pertussis (DTaP, DTP, Tdap) | <input type="checkbox"/> Meningococcal Vaccine (MenACWY) |

Please describe the patient's contraindication(s)/precaution(s) here: _____

Date exemption ends (if applicable) _____

A New York State licensed physician must complete this medical exemption statement and provide their information below:

Name (print) _____ NYS Medical License # _____

Address _____

_____ Telephone _____

Signature _____ Date _____

For Institution Use ONLY: Medical Exemption Status Accepted Not Accepted Date: _____
