



TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name, First Name, Middle Name, Sex, Date of Birth, Child's Address, City/Borough, State, Zip Code, School/Center/Camp Name, District Number, Phone Numbers, Health insurance, Parent/Guardian Last Name, First Name, Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history, Allergies, Attach MAF if in-school medications needed, Does the child/adolescent have a past or present medical history of the following?, Medications

PHYSICAL EXAM, Date of Exam, General Appearance, Describe abnormalities

DEVELOPMENTAL, Nutrition, Hearing, Vision

Validated Screening Tool Used, Screening Results, Describe Suspected Delay or Concern, Dietary Restrictions, Child Care Only

Blood Lead Level (BLL), Lead Risk Assessment, Hemoglobin or Hematocrit, Dental

Child Receives EI/CPSE/CSE services, CIR Number, Physician Confirmed History of Varicella Infection, Report only positive immunity

IMMUNIZATIONS - DATES, DTP/DTaP/DT, Polio, Hep B, Hib, PCV, Influenza, HPV, Tdap, MMR, Varicella, Mening ACWY, Hep A, Rotavirus, Mening B, Other, IgG Titers, Date

ASSESSMENT, Well Child (Z00.129), Diagnoses/Problems (list), ICD-10 Code, RECOMMENDATIONS, Full physical activity, Restrictions (specify), Follow-up Needed, Referral(s)

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, Facility Name, National Provider Identifier (NPI), Address, City, State, Zip, Date Reviewed, I.D. NUMBER, Telephone, Fax, Email, REVIEWER, FORM ID#