# Child & Adolescent Health Examination Form

**TO BE COMPLETED BY THE PARENT OR GUARDIAN**

- **Child's Last Name**: [Blank]
- **First Name**: [Blank]
- **Middle Name**: [Blank]
- **Sex**: [Blank] Male, [Blank] Female
- **Date of Birth (Month/Day/Year)**: [Blank]

**Child's Address**

- [Blank] Hispanic/Latino?
- [Blank] Native Hawaiian/Pacific Islander
- [Blank] Other

**City/Borough**

- [Blank] Health insurance
- [Blank] Parent/Guardian
- [Blank] Foster Parent

**Telephone**

- [Blank] Fax
- [Blank] Email

**Child's Last Name First Name Middle Name Sex**

- [Blank] As a result of膳食REFERENCES, child is at risk for:**
- [Blank] Nutritional deficiency
- [Blank] Weight for height
- [Blank] Height for age

**TO BE COMPLETED BY THE HEALTHCARE PRACTITIONER**

**Birth history (age 0-6 yrs)**

- [Blank] Uncomplicated
- [Blank] Premature: _______ weeks gestation
- [Blank] Complicated by

**Allergies**

- [Blank] None
- [Blank] Epi pen prescribed

**Drugs (list)**

- [Blank] Medications

**Foods (list)**

- [Blank] Nutritional deficiency

**Nutrition**

- [Blank] Caloric deficiency

**Hemoglobin or Hematocrit**

- [Blank] At risk
- [Blank] Not at risk

**OAE**

- [Blank] Referred
- [Blank] Referred

**Vision**

- [Blank] Strabismus?
- [Blank] No

**Hep B**

- [Blank] No
- [Blank] Yes

**Hep A**

- [Blank] No
- [Blank] Yes

**Hib**

- [Blank] No
- [Blank] Yes

**Meningococcal**

- [Blank] No
- [Blank] Yes

**Polio**

- [Blank] No
- [Blank] Yes

**TD**

- [Blank] No
- [Blank] Yes

**Varicella**

- [Blank] No
- [Blank] Yes

**Meningeal**

- [Blank] No
- [Blank] Yes

**Other**

- [Blank] No
- [Blank] Yes

**ASSESSMENT**

- [Blank] Well Child (200.129)
- [Blank] Diagnoses/Problems (list)
- [Blank] ICD-10 Code

**RECOMMENDATIONS**

- [Blank] Full physical activity

**Health care practitioner signature**

- [Blank] Date of form completed

**DOHMH PRACTITIONER I.D.**

- [Blank] Date reviewed
- [Blank] I.D. number

**Addendum attached.**

**TO BE COMPLETED BY THE HEALTHCARE PRACTITIONER**

**DATE OF EXAM:**

- [Blank] Physical Exam WNL
- [Blank] Physical Exam Abnl

**DEVELOPMENTAL**

- [Blank] Delay or concern suspected/confirmed
- [Blank] Early intervention
- [Blank] None

**Nutrition**

- [Blank] Caloric deficiency

**Weight for height**

- [Blank] At risk
- [Blank] Not at risk

**Hematocrit**

- [Blank] At risk
- [Blank] Not at risk

**Hepatitis B**

- [Blank] No
- [Blank] Yes

**Hepatitis A**

- [Blank] No
- [Blank] Yes

**Hib**

- [Blank] No
- [Blank] Yes

**Meningococcal**

- [Blank] No
- [Blank] Yes

**Polio**

- [Blank] No
- [Blank] Yes

**TD**

- [Blank] No
- [Blank] Yes

**Varicella**

- [Blank] No
- [Blank] Yes

**Meningeal**

- [Blank] No
- [Blank] Yes

**Other**

- [Blank] No
- [Blank] Yes

**ASSESSMENT**

- [Blank] Well Child (200.129)
- [Blank] Diagnoses/Problems (list)
- [Blank] ICD-10 Code

**RECOMMENDATIONS**

- [Blank] Full physical activity

**Health care practitioner signature**

- [Blank] Date of form completed

**DOHMH PRACTITIONER I.D.**

- [Blank] Date reviewed
- [Blank] I.D. number

**Addendum attached.**
# Head Start Oral Health Form—Children

## Patient Information

<table>
<thead>
<tr>
<th>Child's name</th>
<th>Date of birth</th>
<th>Parent's/guardian's name</th>
<th>Phone number</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip code</th>
</tr>
</thead>
</table>

This practice is the child’s dental home: □ Yes □ No

## Current Oral Health Status

Does the child have any teeth with untreated decay? □ Yes (decay) □ No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? □ Yes □ No

Are there treatment needs? □ Yes, urgent □ Yes, not urgent □ No treatment needs

## Oral Health Care Services Delivered During Visit

### Diagnostic/Preventive Services

<table>
<thead>
<tr>
<th>Examination</th>
<th>□ Yes □ No</th>
<th>X-rays:</th>
<th>□ Yes □ No</th>
<th>Risk assessment:</th>
<th>□ Yes □ No</th>
<th>Cleaning:</th>
<th>□ Yes □ No</th>
<th>Fluoride varnish:</th>
<th>□ Yes □ No</th>
<th>Dental sealants:</th>
<th>□ Yes □ No</th>
</tr>
</thead>
</table>

### Counseling/Anticipatory Guidance

□ Yes □ No

**Referral to Specialty Care**

(Please specify specialist)

### Restorative/Emergency Care

<table>
<thead>
<tr>
<th>Fillings:</th>
<th>□ Yes □ No</th>
<th>Crowns:</th>
<th>□ Yes □ No</th>
<th>Extractions:</th>
<th>□ Yes □ No</th>
<th>Emergency care:</th>
<th>□ Yes □ No</th>
</tr>
</thead>
</table>

Other: __________________________

(Please specify)

## Future Oral Health Care Services

All treatment completed: □ Yes □ No

Next recall date: ______ / ______ (month/year)

More appointments needed for treatment? □ Yes □ No

If yes: Approximate number of appointments needed: _____ Next appointment: Date: _______ Time: _______

## Additional Information for Parents, Head Start Staff, and Medical Providers

## Oral Health Provider’s Contact Information and Signature

<table>
<thead>
<tr>
<th>Provider name (please print)</th>
<th>Phone number</th>
<th>Fax number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Practice name</th>
<th>Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Provider signature</th>
<th>Date of service</th>
</tr>
</thead>
</table>

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Early Childhood Department
Vision and Hearing Subjective Screening Form

DIRECTIONS: Our governing bodies require that every child in our school has a yearly subjective hearing and vision test done.

A subjective vision test can be performed by holding your finger up, moving it side to side and asking the child to follow it with their eyes. The hearing test can be performed by asking the child a question or to perform a basic task and if they respond appropriately then they have passed.

Once completed, please fill in the information below by selecting if the child passed or failed.

Child’s Name: ___________________________ Date of Test: _____________________

☐ Has Passed the subjective Hearing Screening.

☐ Has Failed the subjective Hearing Screening.

☐ Has Passed the subjective Vision Screening.

☐ Has Failed the subjective Vision Screening.

Physician’s Signature: ___________________________
Name and Address:

__________________________________________________

Telephone: _______________________________

Or Stamp Below