



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

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

DEVELOPMENTAL, Nutrition, Hearing, Vision, Screening Tests, Blood Lead Level, Lead Risk Assessment, Hemoglobin or Hematocrit, Child Receives EI/CPSE/CSE services

CIR Number, Physician Confirmed History of Varicella Infection, Please attach lab reports

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

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

Health Care Practitioner Signature, Date Form Completed, Health Care Practitioner Name and Degree, Practitioner License No. and State, Facility Name, National Provider Identifier (NPI), Address, City, State, Zip, Telephone, Fax, Email, DOHMH ONLY PRACTITIONER I.D., TYPE OF EXAM, Date Reviewed, REVIEWER, FORM ID#