THE NEW YORK CITY DEPARTMENT OF EDUCATION

AVIATION HIGH SCHOOL
STEVEN JACKSON, PRINCIPAL

APPROVED – N.Y. STATE
REGENTS SUBJECT AND EXAMINATIONS
CERTIFICATE #5169

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APPROVED AVIATION MAINTENANCE
TECHNICAL SCHOOL (A/P)
FEDERAL AVIATION ADMINISTRATION
#HW2T887K

June 8, 2017

Dear Parents and Incoming Students:

Welcome to Aviation High School! We hope you enjoyed your visit today. Enclosed please find many of the supplies your child will require for their 9th grade technology classes. Included in the packet you have just purchased are the following items:

Quantity	Item	Price
1 each	Apron	$4.00
2 each	Aviation High School Folders	$1.40
1 each	Pens, Black & Blue	$0.50
1 each	Combination lock	$6.00
1 each	Packet of Drawing Paper	$1.00
1 each	White eraser	$0.80
1 each	12" Plastic Ruler	$0.75
1 each	6" Steel Scale	$3.50
1 each	Eraser Shield	$1.00
1 each	Masking tape	$1.50
1 each	Set of triangles	$4.00
1 each	2H Drawing Pencil	$0.60
1 each	3H Drawing Pencil	$0.60
1 each	4H Drawing Pencil	$0.60
1 each	Circle Guide	$2.25
1each	Goggles	$3.00
1 each	Aviation Dictionary	$18.00
1 each	T Square	$2.50

The cost for the above items is $ 52.00.

Added in the Freshman Packet is the Student Organization Card for the 2017-2018 school years. This card costs $3 and allows students to join all student activities including teams, clubs and trips. It also includes many community discounts.

The total cost for today's purchases, which include the school supplies listed above and the S.O. Card, **is $55.00.** Once again, we wish your child a very successful academic year.

Please confirm all items are in the bag prior to leaving today. No refunds.

Thank you for your purchase.

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 ☐ 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 — Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history (age 0-6 yrs)

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs (list) _____

☐ Foods (list) _____

☐ Other (list) _____

Attach MAF in in-school medications needed

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

☐ Asthma (check severity and attach MAF): ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status: ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ 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)
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____
Explain all checked items above.
☐ *Addendum attached.*

Medications (attach MAF if in-school medication needed)

☐ None ☐ Yes (list below)

_____

PHYSICAL EXAM Date of Exam: ___/___/___

Height _____ cm (____ %ile)

Weight _____ kg (____ %ile)

BMI _____ kg/m² (____ %ile)

Head Circumference (age ≤2 yrs) _____ cm (____ %ile)

Blood Pressure (age ≥3 yrs) _____ / _____

General Appearance:

	NI	Abnl
Psychosocial Development	☐	☐
Language	☐	☐
Behavioral	☐	☐

☐ Physical Exam WNL

	NI	Abnl
HEENT	☐	☐
Dental	☐	☐
Neck	☐	☐
Lymph nodes	☐	☐
Lungs	☐	☐
Cardiovascular	☐	☐
Abdomen	☐	☐
Genitourinary	☐	☐
Extremities	☐	☐
Skin	☐	☐
Neurological	☐	☐
Back/spine	☐	☐

Describe abnormalities:

DEVELOPMENTAL (age 0-6 yrs)

Validated Screening Tool Used? ☐ Yes ☐ No — Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: _____

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes (list below)

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

Child Care Only

Hemoglobin or Hematocrit	___/___/___	_____ g/dL _____ %

Hearing

	Date Done	Results
< 4 years: gross hearing	___/___/___	☐NI ☐Abnl ☐Referred
OAE	___/___/___	☐NI ☐Abnl ☐Referred
≥ 4 yrs: pure tone audiometry	___/___/___	☐NI ☐Abnl ☐Referred

Vision

	Date Done	Results
<3 years: Vision appears:	___/___/___	☐ NI ☐ Abnl
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ___/___ Left ___/___ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental

Visible Tooth Decay	☐ Yes ☐ No
Urgent need for dental referral (pain, swelling, infection)	☐ Yes ☐ No
Dental Visit within the past 12 months	☐ Yes ☐ No

CIR Number

Physician Confirmed History of Varicella Infection ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	

Tdap	___/___/___	___/___/___	
MMR	___/___/___	___/___/___	___/___/___
Varicella	___/___/___	___/___/___	___/___/___
Mening ACWY	___/___/___	___/___/___	___/___/___
Hep A	___/___/___	___/___/___	___/___/___
Rotavirus	___/___/___	___/___/___	___/___/___
Mening B	___/___/___	___/___/___	___/___/___
Other _____	___/___/___	_____	___/___/___

IgG Titers	Date
Hepatitis B	___/___/___
Measles	___/___/___
Mumps	___/___/___
Rubella	___/___/___
Varicella	___/___/___
Polio 1	___/___/___
Polio 2	___/___/___
Polio 3	___/___/___

ASSESSMENT ☐ Well Child (Z00.129) ☐ Diagnoses/Problems (list) — ICD-10 Code

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions (specify) _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: ___/___/___

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ 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: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Facility Name — National Provider Identifier (NPI)

Address — City — State — Zip

Date Reviewed: ___/___/___ — I.D. NUMBER

REVIEWER:

Telephone — Fax — Email

FORM ID#

TO: Aviation High School
FAX NUMBER: 718-349-2787
Attention: Assistant Principal Mathematics
RE: New Student Placement

FAX

Directions: Please complete the form it in its entirety and fax it to the fax number above.

Student Last Name: _____ Student First Name: _____

Address: _____

Parent or Guardian's e-mail: (print neatly)_____

Ask your teacher or guidance counselor to complete the following information:

Name of school currently attending _____

What is your current grade level? (check one): _____8th or _____9th

Guidance counselor's name (please print) _____

Guidance counselor's phone number at school _____

Guidance counselor's e-mail address_____@schools.nyc.gov

Subject Area	Name of Current Class (MO8, Earth Sci, Etc...)	Will you earn acceleration credit for this subject? (Answer yes or no)	Will you be taking a Regents or Proficiency test for this subject? Answer yes or no)
Mathematics			
Science			
English			
Social Studies			
Foreign Lang			