THE CLEAR VIEW SCHOOL DAY TREATMENT CENTER **2016 - 2017**
BRIARCLIFF MANOR, NEW YORK 10510

ANNUAL HEALTH EXAMINATION
(To be filled out by physician)

Date of Exam: ________________________

Child's Name: ________________________ Date of Birth: ________________________

Physical

Height ______________ Weight ______________ Blood Pressure _________________

BMI (Body/Mass Index) _______________________________ Pulse _________________

EYES Ophthalmic ____

Vision without glasses: R. _______ L. _______ B. _________

Vision with glasses: R. _______ L. _______ B. _________

EARS Otoscope ____

Has an audiometric examination ever been done: Yes___ No___

Date of last examination ____

TEETH AND GUMS ____

HEAD AND NECK ____

HEART ____

LUNGS ____

ABDOMEN ____

SKELETAL (scoliosis)

____

NERVOUS SYSTEM ____

Medical History

Describe history of:

Seizures ____

Asthma ____

Ear condition ____

Frequent colds or sore throats ____

Operations ____

Serious injuries ____

2016 - 2017

Child's Name: ____

ANY HISTORY OF ALLERGY TO FOOD OR MEDICATION (Please include reactions):

____

____

How long have you known this child? ____

Is this child receiving medication of ANY sort? yes ____ no ____

If YES: Name of drug(s) ____

Amount of dosage ____

Frequency of administration ____

Reason for use ____

Possible reaction to medication ____

Is this child subject to any significant physical defect or physical condition which the school should take into consideration when planning for this child?

yes ____ no ____

If YES, please explain: ____

COMMENTS OR RECOMMENDATIONS: ____

____

☐ This child is free from contagious illness and is cleared for full physical activities.

☐ There are <u>NO</u> contraindications to his/her competing in competitive sports.

We would be pleased to consult with you about your patient's condition and progress at any time.

Physician Signature: ____

Address: ____

Telephone: ____

Date: ____

THE CLEAR VIEW DAY TREATMENT CENTER **2017 - 2018**
BRIARCLIFF MANOR, NY 10510

IMMUNIZATION POLICY

The Clear View School Day Treatment Center program requires immunization records from all students prior to admission. We comply with yearly reporting requirements to the New York State Department of Health. All students are required to be immunized according to the most current New York State Department of Health schedules. Exceptions may be evaluated for students presenting requests for medical or religious exemption.

In accordance with New York State Department of Health recommendations for control measures related to disease outbreaks, unvaccinated students will be excluded from program until 25 days after isolation of known disease cases in the school community. A student may return to program after one dose of the appropriate immunization and a schedule for full immunization.

____
Child's Name

______________________________ ____________________
Signature of Parent or Guardian Date

Immunization Record

2016 - 2017

Child's Name:____ **DOB:** ______________________**Age:** ___________

Today's Date: ____

Fill in the age and date for each immunization child has received:

Hepatitis B	**#1**	**#2**	**#3**		
Age					
Date					
DTaP (Tetanus)	**#1**	**#2**	**#3**	**#4**	**#5**
Age					
Date					
Tdap	**#1**				
Age					
Date					
Hib	**#1**	**#2**	**#3**		
Age					
Date					
IPV (OPV)	**#1**	**#2**	**#3**	**#4**	
Age					
Date					
MMR	**#1**	**#2**			
Age					
Date					
Varicella	**#1**	**#2**			
Age					
Date					
Pneumonia PCV	**#1**	**#2**	**#3**	**#4**	
Age					
Date					
Meningitis MCV4	**#1**	**#2**			
Age					
Date					
Influenza	**#1**				
Age					
Date					
H1N1	**#1**				
Age					
Date					
HPV	**#1**				
Age					
Date					
PPD	**#1**				
Age					
Date					
Other	**#1**				
Age					
Date					

2016 - 2017

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OVER THE COUNTER MEDICATION PERMISSION FORM

Student's name:____ Date: _______________________

Allergies:____ Date of Birth: _______________

The following medications will be provided by The Clear View School if they have been approved by the child's physician/provider (signature is required) and requested by the guardian; please indicate by checking Yes or No next to medication.

Yes/No	Drug Name	Route	Dosage & Schedule	Indications	Comments
Yes No	Tylenol (or generic) acetaminophen	PO (chewable, elixir, or tabs)	Per label instruction by age/weight	Pain or Fever	Call parent/guardian event of fever
Yes No	Advil (or generic) ibuprofen	PO (chewable, elixir, or tabs)	Per label instruction by age/weight	Pain or Fever	Call parent/guardian event of fever
Yes No	Benadryl (or generic)	PO (elixir, or tabs)	Per label instruction by age/weight	Allergic reactions (hives, insect bites)	Call if allergic reaction, respiratory problems
Yes No	Cepacol lozenges or (generic) (contains benzocaine)	PO	Per label instruction by age/weight	Sore throat	Check allergy history
Yes No	Tums or (generic) calcium carbonate	PO (chewable)	Per label instruction by age/weight	Indigestion, heart burn	
Yes No	Pepto Bismol	PO (chewable, elixir, or tabs)	Per label instruction by age/weight	Upset stomach, nausea, diarrhea, indigestion	
Yes No	Oragel/ Anbesol (or generic, contains benzocaine)	PO	Per label instruction by age/weight	Toothache, sore gums canker sore	Check allergy history
Yes No	Hydrocortisone Cream 1%	Topical	Per label instruction by age/weight	Allergic reactions (contact dermatitis, insect bites	
Yes No	Calagel	Topical	Per label instruction by age/weight	Poison oak, poison ivy	
Yes No	Medicaine Sting Swabs (contains benzocaine)	Topical	Per label instruction by age/weight	Insect bites, bee stings	
Yes No	Antibiotic Ointment	Topical	Per label instruction by age/weight	Superficial cut/ abrasion	Check allergy history
Yes No	Silvadene 1%	Topical	Per label instruction by age/weight	Burns	Check allergy history / sulfa antibiotic

Physician/Provider Signature:_________________________________ Date:______________________
Physician/Provider Stamp: (required):

Parent/Guardian Signature_________________________________ Date:____________________