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 _____

SKIN _____

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 NO 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: _____

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					