THE CLEAR VIEW SCHOOL DAY TREATMENT CENTER **2018 - 2019**
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 _____

2018 - 2019

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

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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					

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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:_____

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ANNUAL DENTAL EXAMINATION

STUDENT'S NAME _____ BIRTHDATE _____

ADDRESS_____

TEETH: General Condition _____

Temporary _____

Permanent _____

Carious _____

GUMS: General Condition _____

THIS PATIENT:
- ☐ requires no dental treatment at this time
- ☐ is under dental treatment at this time
- ☐ will begin dental treatment at this time
- ☐ has completed all current dental treatment

REMARKS OR RECOMMENDATIONS:_____

Dentist Signature _____

Address _____

Telephone _____

DATE OF EXAMINATION: _____