THE CLEAR VIEW SCHOOL DAY TREATMENT CENTER **2020 - 2021**
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 _____

2020 - 2021

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

2020 - 2021

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					