Instructions: Please FAX this completed form and immunization record to 845-298-1064

This is a Medical Clearance for this child to have dentistry done under General Anesthesia at Nyack Hosptial with Dr. Susan Holiday D.M.D. Phone: 845-548-7846

NAME _____ **DOB** _____

PATIENT PHONE _____ **DATE OF SERVICE** _____

DIAGNOSIS ___*CARIES*_____ **PLANNED PROCEDURE** _____*DENTISTRY* / *GENERAL ANESTHESIA*_____

PRESENT / RECENT INTERCURRENT ILLNESS _____

MEDICATIONS (INCLUDE ASA) _____

ALLERGIES _____ **LAST PPD** _____ **IMMUNIZATIONS UTD?** _____

ETON _____**DRUGS** _____ **LMP**_____

MEDICAL SURGERY HISTORY (PLEASE INCLUDE BRIEF DETAILS OF ANY "YES" ANSWER)

1. PREVIOUS SURGERY / ANESTHESIA _____

2. FAMILY ANESTHESIA HX _____

3. PREMATURITY (APNEA) _____

4. RESPIRATORY (E.G. SNORING, APNEA, CROUP, ASTHMA) _____

5. CARDIOVASCULAR (E.G. HEART MURMUR, HTN, CHD) _____

6. G.I. (REFLUX) _____

7. RENAL / URINARY _____

8. HEMATOLOGIC/ONCOL (E.G. BLEEDING, TRANSFUSIONS, CHEMO/RT) _____

9. ENDOCRINE / METABOLIC _____

10. NERO / SEIZURE _____

11. RETARDATION / BEHAVIOR _____

PHYSICAL EXAMINATION

DOB _____ **WT.** _____**KG. HT.**_____**CM. BP.** _____/_____ **HR** _____ **T** _____**C°**

PLEASE INDICATE IF THERE ARE ANY ABNORMALITIES IN THE FOLLOWING
(PLEASE INCLUDE BREIF DETAILS OF ANY ABNORMALITIES) :

HEART _____

LUNGS _____

HEENT (E.G. HEART MURMUR, HTN, CHD) _____

KIDNEYS _____

ABDOMEN _____

EXTREMITIES _____

MENTAL STATUS _____

ABNORMAL LABORATORY RESULTS_____

OTHER CONDITIONS (PLEASE LIST)_____

IMPRESSION_____

RECOMMENDATIONS_____

SIGNATURE _____ **MD/NP** **OFFICE TELEPHONE** _____

PRINT NAME _____ **DATE** _____

By signing this medical clearance form. I certify that I have evaluated this patient regarding his / her clinical condition.