

J&R Pediatrics

www.jnrpediatrics.com
52, Lincoln Hwy, St. 1A, Edison, NJ, 08820

jnrpediatric@gmail.com
P: 732-366-3234, F: 732-605-5803

MEDICAL CLEARANCE

Today's Date: _____

Name: _____ D.O.B.: _____ M / F Age: _____

Historian: _____ Relationship to Patient: _____

Referred by: _____

Medications: _____

Allergy: (Food/ Medication) Yes No _____

ROS/HPI: (Date of Onset, Date Resolved, Severity)

Within the past 14 days, have you been in close physical contact with a person who is known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19? (date) _____

Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19? (date started) _____

COVID-19 test Medically Necessary? Yes No

Are you currently waiting on the results of a COVID-19 test? (date, facility) _____

General Normal Abnormal _____

(*confusion, *too sleepy, *blue color of skin, *swelling of hands and feet)

Head/Scalp/Skin Normal Abnormal _____

(*headache, *rash)

Eyes/Ears/Nose/Throat Normal Abnormal _____

(*red eyes, *strawberry tongue, *taste, *smell)

Chest/Lungs/Heart Normal Abnormal _____

(*chest pain, *SOB)

Abdomen Normal Abnormal _____

(*vomit, *diarrhea, *abdominal pain, *decreased urine)

Past History (Chronic): _____

Laboratory Data: _____

PHYSICAL EXAMINATION:

HT: _____ cm. WT: _____ kg. BMI _____ % HC: _____ cm. B.P.: _____ R: _____ P: _____ T: _____

General Appearance: _____

Lungs: _____

Skin: _____

Abdomen: _____

Adenopathy: _____

Extremities: _____

H.E.E.N.T: _____

Musculoskeletal: _____

Heart: _____

Neuro/Psych: _____

Cleared Yes No

Not Cleared (reason) _____

MD/DO/ARNP/PA-C _____

Follow Up Appt: _____

Date/Time _____