PORTOFINO PEDIATRICS

Nivia E. Vazquez, M.D. • 925 N.E. 30th Ter. Suite 202 • Homestead, FL 33033 • P: 305.246.1030 • F: 305.246.2387

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:___________________________

Skin:_____________________________________

Adenopathy:________________________________

H.E.E.N.T:__________________________________

Heart:_____________________________________

Lungs:______________________________________

Abdomen:___________________________________

Extremities:_________________________________

Musculoskeletal:______________________________

Neuro/Psych:_________________________________

Cleared Yes ☐ No ☐

Not Cleared (reason)______________________________

Follow Up Appt: _______________________________

MD/DO/ARNP/PA-C ___________________________

Date/Time _____________________________ ____