American Pediatric Sedation Center

Medical Clearance Form

Patient's Name: _____ Patient's Date of Birth: _____

Patient's Phone Number (Home):_____ (Cellular):_____

Date of Medical Clearance: _____ Scheduled Date of Procedure:_____

Pediatricians or Primary Care Physicians (PCP) Please Complete ENTIRE Form Below:

List of Allergies:	Type of Reaction

Current Medications:	Dose (mg)	Frequency

Please check ALL Pertinent Medical Conditions – Conditions in SHADED area are specific to sedation

☐ Recent URI/Cough/Cold/Flu	☐ Diabetes Type I	☐ Epilepsy/History of seizures
☐ Enlarged Tonsils/Adenoids	☐ Diabetes Type II	☐ History of VP shunts
☐ Obstructive Sleep Apnea	☐ Thyroid Problems	☐ Hydrocephalus
☐ Obesity	☐ Liver Disease	☐ Autism
☐ Cardiac anomalies (PDA/VSD/ASD/PFO)	☐ Kidney Disease	☐ Developmental Delays
☐ Cardiac murmur	☐ Anemia	☐ Down's Syndrome
☐ Asthma	☐ Sickle Cell Disease	☐ Cerebral Palsy
☐ Airway/Trachea anomaly	☐ Hemophilia	☐ ADD/ADHD
	☐ Bleeding/Clotting Disorders	☐ Failure to thrive/underweight

PHYSICAL EXAM:

Systems	Findings:	Vital Signs	
HEENT:		Height:	
Does patient have enlarged tonsils and/or adenoids? YES or NO		Weight (kg):	
Cardiac:		Is patient overweight or obese? YES or NO	
Lungs:		Blood Pressure:	
Abdomen:		Heart Rate:	
Extremities:		Temperature:	
Neuro/Psych:		Date of Menarche (Females): _____	

IS ANTIBIOTIC PROPHYLAXIS RECOMMENDED? (CIRCLE ONE) YES or NO

IS THIS PATIENT MEDICALLY CLEAR FOR SEDATION? (CIRCLE ONE) YES or NO

PHYSICIAN NAME	PHYSICIAN SIGNATURE	DATE

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