

**SADDLE RIVER DAY SCHOOL  
REPORT OF ANNUAL PHYSICAL EXAM  
2006-2007**

**Name:** \_\_\_\_\_

**Medical History** (give dates)

Accidents _____	Ear Infections _____	Measles _____	Scarlet Fever _____
Allergy _____	Encephalitis _____	Meningitis _____	Strep Throat _____
Chicken Pox _____	German Measles _____	Mumps _____	Tonsilitis _____
Congenital Anomaly _____	Heart Disease _____	Operations _____	Tuberculosis _____
Convulsions _____	Hernia _____	Poliomyelitis _____	Whooping Cough _____
Diabetes _____	Kidney Disease _____	Rheumatic Fever _____	Other _____

**Pertinent Family Medical History**

\_\_\_\_\_

**Physician's Examination**

Date: \_\_\_\_\_ (O) Normal      (X) Abnormal (Comment: specify consultation requested)

Age: \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_ Hgt. \_\_\_\_\_ Wgt. \_\_\_\_\_

Physical Development \_\_\_\_\_

Nutritional Status \_\_\_\_\_

Skin \_\_\_\_\_

Eyes \_\_\_\_\_ Sclera \_\_\_\_\_ Pupils \_\_\_\_\_ Light & Distance \_\_\_ r \_\_\_ l \_\_\_ Glasses \_\_\_\_\_

Ears \_\_\_\_\_ Canals \_\_\_ r \_\_\_ l \_\_\_ Drums \_\_\_ r \_\_\_ l \_\_\_

Nose \_\_\_\_\_ septum \_\_\_\_\_ turbinates \_\_\_\_\_

Mouth \_\_\_\_\_ lips \_\_\_\_\_ tongue \_\_\_\_\_ pharynx \_\_\_\_\_

Teeth \_\_\_\_\_ gingiva \_\_\_\_\_

Neck \_\_\_\_\_ mobility \_\_\_\_\_ lymph nodes \_\_\_\_\_ thyroid \_\_\_\_\_

Throat \_\_\_\_\_ shape \_\_\_\_\_ symmetry \_\_\_\_\_

Lungs \_\_\_\_\_

Heart \_\_\_\_\_ rate \_\_\_\_\_ rhythm \_\_\_\_\_ murmur \_\_\_\_\_

Abdomen \_\_\_\_\_ liver \_\_\_\_\_ spleen \_\_\_\_\_ hernias \_\_\_\_\_

Ano-Genital \_\_\_\_\_ anus \_\_\_\_\_ penis \_\_\_\_\_ testicles \_\_\_ r \_\_\_ l \_\_\_ labia \_\_\_\_\_

Spine \_\_\_\_\_

Lower Extremities \_\_\_\_\_ range of motion \_\_\_\_\_ development \_\_\_\_\_ strength \_\_\_\_\_

Upper Extremities \_\_\_\_\_ range of motion \_\_\_\_\_ development \_\_\_\_\_ strength \_\_\_\_\_

Cranial Nerve \_\_\_ I-XII \_\_\_\_\_ Gait \_\_\_\_\_ Coordination \_\_\_\_\_

**I certify that I have examined the above student and give my approval for this student's participation in all team sports.**

**(Physician's Stamp)**

\_\_\_\_\_  
Signature M.D.

(over)

<u>VACCINE TYPE</u> Mo/Yr	<u>PRIMARY SERIES</u>				<u>BOOSTERS</u>	
	<u>Disease</u> <u>Mo/Yr</u>	<u>1st dose</u> <u>Mo/Yr</u>	<u>2nd Dose</u> <u>Mo/Yr</u>	<u>3rd Dose</u> <u>Mo/Yr</u>	<u>Mo/Yr</u>	<u>Mo/Yr</u>
Diphtheria & Tetanus (DPT and/or Td)						
Oral Polio (if monovalent, indicate type: I, II, III in corner box)						
Measles						
Rubella						
Mumps						
Mantoux Test						
Other (Specify)						