REYNOLDS/BOGERT HEALTH OFFICE
UPPER SADDLE RIVER SCHOOL DISTRICT
Physical Examination Report

Name: ______________________ **Age:** _______ **Date of Birth:** ___________________

Address: ____________________ **City/State/Zip:** ____________________ **Home Phone:** ___________________

School: ____________________ **Grade:** ____________ **Sex:** ________________

PHYSICIAN OR PROVIDER INFORMATION – PLEASE COMPLETE BOTH SIDES

Exam Date: __________________

Height: _________ **Weight:** _________ **Blood Pressure:** ______/_______ **Pulse:** _____bpm.
Vision: R 20/____ L 20/ ____ **Corrected:** Y N **Contacts:** Y N **Glasses:** Y N
Hearing : R_______L_______

	Normal	Abnormal Findings	Comments
Head/Neck			
Eyes/Sclera/Pupils			
Ears			
Nose/Mouth/Throat			
Heart: Murmurs/Rhythms			
Lungs: Auscultation/Percussion			
Chest Contour			
Skin			
Abdomen: Assessment (inc. liver, spleen)			
Tanner Stage: Testes/Onset of Menses:			
Hernia	No	Yes/Possible	
Neck/Back/Spine: Range of Motion:			
Scoliosis:			
Upper Extremities			
Lower Extremities			
Neurological: Balance & Coordination: Romberg:			
Heel Walk:			
Tandem Walk:			
Nose Touch:			
Toe Walk:			

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ALLERGIES:
Medications currently in use:
Additional Observations:
Any defect of vision, hearing or speech that the school could compensate for by proper seating, etc.? Any condition limiting classroom activity or physical education? Any condition which may result in a classroom emergency? Any emotional, mental or physical condition requiring periodic medical observation.?

Immunizations

DPT __________ __________ __________ __________ __________ __________

POLIO __________ __________ __________ __________ __________
(indicate OPV OR IPV)

MMR __________ __________

HIB __________ __________ __________ __________

Hepatitis B __________ __________ __________

Varivax __________ PCV (**pneumococcal vaccine)** __________ __________ __________

Other (specify) __________

TB Screening __________ __________

(Mantoux Test) **date** **result**

Physician: ______________________ **Phone:** ______________________ **Fax:** ______________________

Address: ______________________ **City/State/Zip:** ______________________

EXAMINED BY: Physician's/Provider's Stamp:

Family Physician/Provider_____

____MD____DO____NP____PA

PHYSICIAN'S/PROVIDER'S SIGNATURE:____