

**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/

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:			

Continued on back of page

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: _____