

# Brewster Academy 2008-2009 Physical Exam for Returning Students

To be completed by a M.D., D.O., A.R.N.P., or P.A.

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Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ **Allergies** \_\_\_\_\_

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Routine or P.R.N. medications (if yes, prescribing MD please complete Medication information form)

**IMMUNUZATION BOOSTERS GIVEN:** \_\_\_\_\_

**B.P.** \_\_\_\_\_ / \_\_\_\_\_      **H.R.** \_\_\_\_\_      **R.R.** \_\_\_\_\_      **Height** \_\_\_\_\_      **Weight** \_\_\_\_\_

**Are there abnormalities in any of the following systems? (please explain)**

Head, ears, eyes, nose, throat & hearing \_\_\_\_\_  
Respiratory \_\_\_\_\_  
Cardiovascular \_\_\_\_\_  
Gastrointestinal \_\_\_\_\_  
Musculoskeletal \_\_\_\_\_  
Metabolic/Endocrine \_\_\_\_\_  
Neuro-psychiatric \_\_\_\_\_  
Skin \_\_\_\_\_

Have there been any changes in the past year that will effect medical care of this student?

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Please note that the following screenings were done and note any abnormal findings:

Hernia (If male) \_\_\_\_\_ Completed  
Posture/Scoliosis \_\_\_\_\_ Completed  
Vision without glasses: \_\_\_\_\_ / \_\_\_\_\_      With glasses: \_\_\_\_\_ / \_\_\_\_\_

Are there any medical restrictions or physical limitations our Athletic Dept. should be aware of? No \_\_\_\_\_  
Yes \_\_\_\_\_ (Please explain) \_\_\_\_\_

Is there anything else we should be aware of (hospitalizations, ongoing treatments, etc) in order to provide good medical care for this student? \_\_\_\_\_

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Signature of M.D., D.O., A.R.N.P, or P.A.

Date

Printed Name of Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

Please attach your business card.

**ALL MEDICAL FORMS MUST BE RECEIVED BY JULY 1<sup>ST</sup>.**