

Brewster Academy 2008-2009 Physical Exam for New Students

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

Name of Student _____ Date of Birth _____ Age _____ **Allergies** _____

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

Are NH required immunizations current? (See immunization form) _____ Boosters given: _____

B.P. _____ / _____ **H.R.** _____ **R.R.** _____ **Height** _____ **Weight** _____

Required tests: Urinalysis: Sugar _____ Albumin _____ Micro _____ Hgb/Hct _____

TB: (Required within 6 months of arrival on campus)

Date: _____ / _____ / _____ mm induration: _____ neg or pos: _____

If positive, CXR required. CXR results: _____

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

Head, ears, eyes, nose, throat _____

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?

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? _____

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 1ST.