

## Concordia Learning Center at St. Joseph's School for the Blind

761 Summit Avenue, Jersey City, NJ 07307

(201) 876-5432 / FAX (201) 876-5430

### ANNUAL MEDICAL REVIEW

Name of Student: \_\_\_\_\_ School Year: \_\_\_\_\_

**Dear Doctor:**

Please give the appropriate tests and immunizations to your patients, so that they do not risk losing time from school.

**Immunizations (record any new immunizations since last physical of student):**

<u>Vaccine</u>	<u>Date Given</u>	<u>Doctor's Name</u>	<u>Date Next Dose Due</u>

*Residential students and students entering school for the first time are required to have a mantoux. Residential students are required to repeat testing every three years.*

**A. History**

1. Indicate any known communicable diseases: \_\_\_\_\_  
\_\_\_\_\_
2. Previous hospitalizations or surgeries: \_\_\_\_\_  
\_\_\_\_\_
3. Any Significant changes in child's general health since last exam?  
\_\_\_\_\_

**B. Clinical Examination**

1. Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Temp.: \_\_\_\_\_ Pulse: \_\_\_\_\_ Resp.: \_\_\_\_\_ B.P.: \_\_\_\_\_
2. Vision: \_\_\_\_\_ Structure of eyes: \_\_\_\_\_
3. Hearing: \_\_\_\_\_ Structure of ears: \_\_\_\_\_  
Does child wear hearing aids: \_\_\_\_\_ Date of last hearing test? \_\_\_\_\_
4. ENT: \_\_\_\_\_
5. Tonsils and adenoids: \_\_\_\_\_ Normal \_\_\_\_\_ Enlarged \_\_\_\_\_ Removed \_\_\_\_\_ Interference w/response
6. Teeth and Gums: \_\_\_\_\_
7. Neck: \_\_\_\_\_
8. Lymphatic System: \_\_\_\_\_
9. Respiratory System: \_\_\_\_\_
10. Cardiovascular System: \_\_\_\_\_
11. Gastrointestinal System: \_\_\_\_\_
12. Genitourinary System: \_\_\_\_\_
13. Muscular System: \_\_\_\_\_
14. Skeletal System: \_\_\_\_\_  
What is his/her posture? \_\_\_\_\_ Physical Development? \_\_\_\_\_
15. Neurological System: \_\_\_\_\_

**ANNUAL MEDICAL REVIEW (Continued)**

**C. Other Medical Conditions/Needs:**

1. Seizures: \_\_\_\_\_ Yes \_\_\_\_\_ No  
If "yes" Please indicate frequency and type if known: \_\_\_\_\_
  
2. Special Dietary Needs: \_\_\_\_\_ Yes \_\_\_\_\_ No **(Attach prescriptions for special orders)**  
State of Nutrition: \_\_\_\_\_
  
3. Allergies, sensitivities to food, drugs, other: \_\_\_\_\_  
\_\_\_\_\_
  
4. Mental Health Problems (Behavioral/Psychiatric Disorders): \_\_\_\_\_  
\_\_\_\_\_

**D. Additional information/recommendations:**

(Please indicate if there are limitations/restrictions regarding physical activities)

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Physician's Printed Name**

\_\_\_\_\_  
**Date of Examination**

\_\_\_\_\_  
**Physician's Signature**

**Physician's Office Address:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Physician's Office Phone #:** \_\_\_\_\_