OVERBROOK SCHOOL FOR THE BLIND

ADMISSION HISTORY AND PHYSICAL HEALTH EVALUATION

Student's Name: _____ *Date of Exam:* _____

Student's Date of Birth: _____

Height: _____ *Weight:* _____ *Blood Pressure:* _____

Medical History: List any new problems or occurrences (accidents, operations, etc.) that have happened since the date of the last report. If this is a first-time report, please list information since birth.

_____

_____

_____

_____

_____

Health Systems Physical Review: Check appropriate answer. If abnormal, identify problem.

	NORMAL	ABNORMAL	COMMENTS/PROBLEMS
1. Growth & Development			
2. General Appearance			
3. Head			
4. Eyes - Fundi			
5. Ears			
6. Nose			
7. Pharynx			
8. Teeth Upper Lower			
9. Thyroid			
10. Cardiovascular			
11. Lungs			

Student's Name: _____

	NORMAL	ABNORMAL	COMMENTS/PROBLEMS
12. Chest and Breasts			
13. Abdomen-Hernia			
14. Genitalia Male Female			
15. Extreities Pulses Hips			
16. Skin			
17. Rectum			
18. Lymph Nodes			
19. Behavior			
20. Neurological			
21. Spine			
22. Tanner Score #			

**** Immunizations: (Must be completed)***

Please list all immunizations

(Note: Tetanus must be within 10 years. TB tine must be within 2 years. If student is being considered for Residential placement TB MANTOUX must be given in place of TB Tine. Hepatitis B Vaccination is required of all students)

P.P.D. Test Date: _____ Test Result: _____

(THIS IS REQUIRED FOR STUDENT TO START SCHOOL)

If immunizations are attached please check:

☐ **See attached Report.**

Student's Name: _____

* Is child free from communicable/contagious diseases? If not, please explain.

Yes [ ] No [ ]

_____

_____

_____

_____

_____

* List all current medications and reason for medication.

Name of Drug	Dose	Diagnosis (Being Treated For)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

* List any behavioral, emotional or psychiatric problems. Indicate name of physician and the medication and therapeutic interventions.

_____

_____

_____

_____

_____

Student's Name: _____

Impressions:

1. Positive physical findings: _____

_____

_____

_____

_____

2. Problems: _____

_____

_____

_____

_____

3. Plan: _____

_____

_____

_____

_____

PHYSICIAN'S NAME (please print) _____

DATE: _____

PHYSICIAN SIGNATURE _____

Address: _____

_____

Phone: _____