

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

**PRIVATE PHYSICIAN'S REPORT OF
PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE**

DATE _____ 20 _____

NAME OF SCHOOL _____ GRADE _____ HOMEROOM _____

NAME OF CHILD			DATE OF BIRTH	SEX
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
Last	First	Middle		

ADDRESS _____

No. and Street	City or Post Office	Borough or Township	County	State	Zip Code
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**MEDICAL HISTORY
IMMUNIZATIONS AND TESTS**

VACCINE	Enter Month, Day and Year Each Immunization Was Given									
	DOSES									
	1		2		3		4		5	
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, Td	/	/	/	/	/	/	/	/	/	/
Polio (Circle): OPV, IPV	/	/	/	/	/	/	/	/	/	/
Measles, Mumps, Rubella	/	/	/	/	/	/	/	/	/	/
Hepatitis B	/	/	/	/	/	/	/	/	/	/
HIB	/	/	/	/	/	/	/	/	/	/
Varicella	/	/	/	/	/	/	/	/	/	/
Other _____										

- MEDICAL EXEMPTION** The physical condition of the above named child is such that immunization would endanger life or health
- RELIGIOUS EXEMPTION** (Includes a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian)

If Applicable:

Tuberculin Tests Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	Results (mm)		Signature		

Follow-Up of significant tuberculin tests: _____

Parent/Guardian notified of significant findings on. _____ Date _____

Results of Diagnostic Studies: _____ Date _____

Preventive Anti-Tuberculosis – Chemotherapy ordered. NO YES _____ Date _____

(Continued on Back)

Significant Medical Conditions (✓)

	Yes	No	If Yes, Explain
Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemical Dependency.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuromuscular Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthopedic Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (Specify).....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might effect his/her education? If so, specify.

Report of Physical Examination (✓)

	Normal	Abnormal	Not Examined	Comments
• Height (inches)				
• Weight (pounds) BMI				
• Pulse ()				
• Blood Pressure /				
• Hair/Scalp				
• Skin				
• Eyes/Vision				
• Ears/Hearing				
• Nose and Throat				
• Teeth & Gingiva				
• Lymph Glands				
• Heart – Murmur, etc.				
• Lung – Adventitious Findings				
• Abdomen				
• Genitourinary				
• Neuromuscular System				
• Extremities				
• Spine (Presence of Scoliosis)				

Date of Examination

Signature of Examiner

PRINT Name of Examiner

Address

Telephone Number