

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

**MEDICAL HISTORY
IMMUNIZATIONS AND TESTS**

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

- MEDICAL EXEMPTION The physical condition of the above named child is such that immunization would endanger life or health
- RELIGIOUS EXEMPTION (Include 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

Result of Diagnostic Studies: _____ Date

Preventive Anti-Tuberculosis – Chemotherapy ordered. No Yes _____ Date

Significant Medical Conditions (✓)

	Yes	No	
	□	□	If Yes, Explain
Allergies.....	□	□	_____
Asthma.....	□	□	_____
Cardiac.....	□	□	_____
Chemical Dependency.....	□	□	_____
Drugs.....	□	□	_____
Alcohol.....	□	□	_____
Diabetes Mellitus.....	□	□	_____
Gastrointestinal Disorder.....	□	□	_____
Hearing Disorder.....	□	□	_____
Hypertension.....	□	□	_____
Neuromuscular Disorder.....	□	□	_____
Orthopedic Condition.....	□	□	_____
Respiratory Illness.....	□	□	_____
Seizure Disorder.....	□	□	_____
Skin Disorder.....	□	□	_____
Vision Disorder.....	□	□	_____
Other (Specify).....	□	□	_____

Are there any special medical problems or chronic, diseases which require restriction of activity, medication or which might affect 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 and 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