

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

DATE _____ 19 _____

NAME OF SCHOOL _____ GRADE _____ HOMEROOM _____

NAME OF CHILD _____	AGE _____	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				BOOSTERS & DATES	
	DOSES					
Diphtheria and Tetanus*	1 / /	2 / /	3 / /	4 / /	5 / /	
Polio	1 / /	2 / /	3 / /	4 / /	5 / /	
Measles, Mumps, Rubella	1 / /	2 / /				
Hepatitis B	1 / /	2 / /	3 / /			
HIB	1 / /	2 / /	3 / /			
Other _____						

* Tetanus and Diphtheria are usually received in combined vaccines such as DTP, DT, or Td

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.)

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	<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"/>	_____

Report of Physical Examination (✓)

	Normal	Abnormal	If Abnormal, Explain
• Height (inches)			
• Weight (pounds)			
• Pulse ()			
• Blood Pressure /			
• Hair/Scalp			
• Skin			
• Eyes — Visual Acuity R / L /			
• Eyes — Color Vision			
• Ears — Hearing dB R L			
• Nose and Throat			
• Teeth and Gingiva			
• Lymph Glands			
• Heart — Murmur, etc.			
• Lung — Adventitious Findings			
• Abdomen			
• Genitalia			
• Neuromuscular System			
• Extremities			
• Spine (Presence of Scoliosis)			

Date of Examination

Signature of Examiner

Print Name of Examiner

Address