H511.336 (Rev 5/02)

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
Last First Middle		☐ M ☐ F

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			BOOSTERS & DATES	
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 (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 _____.

Result of Diagnostic Studies: _____.
Preventive Anti-Tuberculosis – Chemotherapy ordered. ☐ No ☐ Yes _____ Date

Significant Medical Conditions (√)
If Yes, Explain

	Yes	No	
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 Finding				
▪ Abdomen				
▪ Genitourinary				
▪ Neuromuscular System				
▪ Extremities				
▪ Spine (Presence of Scoliosis)				

_____
Date of Examination

_____ _____
Signature of Examiner **PRINT** Name of Examiner

_____ _____
Address Telephone Number

HAMPTON
A Tradition of Excellence

SCHOOL HEALTH SERVICES
Private Dental Report

Name _____

School _____ Grade _____

The above named child was given a complete dental examination on _____.
Date

- Prophylaxis performed? Yes _____ No _____
- Topical fluoride applied? Yes _____ No _____
- Carious lesions found? Yes _____ No _____
- Under treatment? Yes _____ No _____
- Referred for orthodontics? Yes _____ No _____

Additional comments _____

_____

_____ _____
Dentist Signature Address

_____ _____
Print Dentist's Name Phone

Dent.100a
Rev 6/10

Poff Elementary School • 2990 Haberlein Road Gibsonia, PA 15044-8230
Telephone: 412-492-6337 • Fax: 724-443-4429

Hampton Township School District
Elementary Health Services

Dear parents,
As of January 1, 2018, Allegheny County requires lead testing for all children in the county. **Children entering Kindergarten this fall will need to show that they have had two tests to measure his or her blood lead level.**

Here is what you need to know:

1. The new regulations require blood lead testing for all children at around 9-12 months old and again at around 24 months old. If your child did not have one or both of these tests, he or she should have a blood lead test as soon as possible.
2. We will accept any written proof from your child's doctor showing when the blood lead tests were done. A sample blood lead level testing form is attached that can be filled out by you and signed by the child's doctor. Or, you can provide other written proof showing when the tests were performed.
3. If your child doesn't have a doctor, doesn't have insurance, or if your insurance won't cover blood lead testing, here are health clinics nearby that can do the test:

   North Side Christian Health Center
   816 Middle Street
   Pittsburgh, PA 15212
   412-321-4001

   Hill House Health Center - Primary Care Health Services, Inc.
   1835 Centre Avenue, Suite 190
   Pittsburgh, PA 15219
   412-261-0937

   Lead Testing at the Allegheny County Health Department Immunization Clinic
   Hartley Rose Building

   425 First Avenue, 4th Floor
   Pittsburgh, PA 15219
   (412) 578-8062
   Tuesdays 9 a.m.-12 p.m. and Thursdays 12-4 p.m.

4. You can request an exemption to the blood lead testing requirement if you have strong moral or religious objection to the test. A sample exemption form is included on the second page of the sample blood lead testing form.
5. Talk with your child's doctor about next steps if your child has elevated blood lead levels. You can also visit www.achd.net/lead for more information about resources to reduce lead exposure at home.
6. A child will not be excluded from school if they have not had blood lead tests at 9-12 months and at 24 months, or if you don't have documentation of tests that have been performed. However, parents should have a "catch up" test as soon as possible.

Allegheny County Health Department

Lead Testing Record

To be filled out by parent or guardian

Student first and last name: _____

Birthdate: _____/_____/_____

Address: _____ City: _____

State: PA Zip code: _____-_____

Parent or guardian name: _____

To be filled out by health care provider

Date of most recent lead test: ____/_____/____

X _____

Signature (PLEASE CIRCLE - physician, certified registered nurse practitioner, physician assistant, health department staff)

Date: ____/_____/____

If exemption is requested, please fill out back of form.

Other acceptable proof of testing: any written statement by the child's health care provider.

 Complete only if exemption is requested

Allegheny County Health Department

Statement of Exemption to Lead Testing Regulation

To be filled out by parent or guardian

Student first and last name: _____

Birthdate: ____/____/____

Address: _____ City: _____

State: PA Zip code: _____-_____

Parent or guardian name: _____

Religious or Strong Moral/ Ethical Conviction Exemption

State your reason/s for requesting this exemption (required): _____

_____

_____

_____

Signed _____ Date ____/____/____
(Parent or guardian)

To be filled out by health care provider

Medical Exemption

The physical condition of the above-named child is such that blood lead testing may be detrimental to his/her health.

Signed _____ Date ____/____/____
(Physician)