



Dear Parent(s)/Guardian,

The Pennsylvania Public School Code requires that both a physical and a dental examination be completed on every child entering school for the first time in either kindergarten or first grade.

In addition, physical and dental examination reports are required of students entering all other grades if these reports are not transferred from the child's previous school.

Physical and dental examination reports should be completed by your child's health care providers and returned to the school nurse on or before the first day of school. **These reports must be dated no earlier than one year prior to school entry.** Reports dated earlier are not valid and cannot be accepted.

Please contact me if you have questions or problems complying with this regulation. Your cooperation is greatly appreciated.

Sincerely,

Dana Herald, R.N., C.S.N.
Elementary School Nurse
herald@ht-sd.org

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

DATE _____ 20 _____

NAME OF SCHOOL _____ GRADE _____ HOMEROOM _____

NAME OF CHILD _____ _____ _____ <small style="display: flex; justify-content: space-between; width: 100%;"> Last First Middle </small>	DATE OF BIRTH _____	SEX <input type="checkbox"/> M <input type="checkbox"/> F
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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			BOOSTERS & DATES	
	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** (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 _____

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"/>	_____

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



Private Dental Report

Student's 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