

**STATE COLLEGE AREA SCHOOL DISTRICT  
STUDENT SERVICES  
PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION**

NAME OF CHILD \_\_\_\_\_

LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ GRADE \_\_\_\_\_ SEX \_\_\_\_\_

IMMUNIZATION STATUS: \*\*\*\*GIVE DATE OF LAST BOOSTER AND LAST TB TEST\*\*\*\*

TRIPLE ANTIGEN (DPT) _____	MEASLES, MUMPS, RUBELLA _____
TETANUS-DIPHTHERIA _____	MEASLES, MUMPS, RUBELLA BOOSTER _____
TETANUS TOXIOD _____	MEASLES BOOSTER _____
Tdap _____	MUMPS BOOSTER _____
POLIO BOOSTER _____	MENINGOCOCCAL _____
VARICELLA VACCINE _____	VARICELLA BOOSTER _____
VARICELLA DISEASE _____	TUBERCULIN TEST DATE _____ RESULT _____
HEPATITIS B 1. _____ Month _____ Year _____ 2. _____ 3. _____	
OTHER: _____	
HEPATITIS A 1. _____ 2. _____	
HPV 1. _____ 2. _____ 3. _____	

**MEDICAL HISTORY:** (GIVE SIGNIFICANT DETAILS, INCLUDING SERIOUS ILLNESS ALLERGIES, OPERATIONS, ACCIDENTS)

**REPORT OF EXAMINATION:** (ELABORATE BELOW ON POSITIVE FINDINGS)

B/P \_\_\_\_\_ PULSE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ VISION R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ +LENS WEARS CORRECTIVE LENS YES  NO

	NORMAL	ABNORMAL		NORMAL	ABNORMAL		NORMAL	ABNORMAL
GENERAL NUTRITION	<input type="checkbox"/>	<input type="checkbox"/>	GLANDS	<input type="checkbox"/>	<input type="checkbox"/>	SKELETON	<input type="checkbox"/>	<input type="checkbox"/>
SKIN	<input type="checkbox"/>	<input type="checkbox"/>	HEART	<input type="checkbox"/>	<input type="checkbox"/>	POSTURE	<input type="checkbox"/>	<input type="checkbox"/>
EYES	<input type="checkbox"/>	<input type="checkbox"/>	LUNGS	<input type="checkbox"/>	<input type="checkbox"/>	EMOTIONAL STATUS	<input type="checkbox"/>	<input type="checkbox"/>
EARS	<input type="checkbox"/>	<input type="checkbox"/>	ABDOMEN	<input type="checkbox"/>	<input type="checkbox"/>	HEARING	<input type="checkbox"/>	<input type="checkbox"/>
NOSE AND THROAT	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY	<input type="checkbox"/>	<input type="checkbox"/>	SCOLIOSIS (BENDING POSITION)	<input type="checkbox"/>	<input type="checkbox"/>
TEETH AND GINGIVA	<input type="checkbox"/>	<input type="checkbox"/>	NEURO MUSCULAR SYSTEM	<input type="checkbox"/>	<input type="checkbox"/>			

IS THE CHILD UNDER TREATMENT? YES  NO

SHOULD THIS CHILD HAVE RESTRICTIONS ON PLAY OR PHYSICAL EDUCATION ACTIVITIES? RECOMMENDATIONS:

WHAT OTHER RECOMMENDATIONS DO YOU WISH TO MAKE TO THE TEACHER OR SCHOOL NURSE WHICH MIGHT BE OF BENEFIT TO THIS CHILD FROM THE POINT OF VIEW OF EITHER PHYSICAL OR MENTAL HEALTH?

SIGNATURE OF EXAMINING PHYSICIAN	ADDRESS	
PHYSICIAN'S PRINTED NAME	TELEPHONE	DATE OF EXAMINATION