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. _____ Date

Results of Diagnostic Studies: _____ Date

FAX TO SCHOOL NURSE
610-838-7473

Preventive Anti-Tuberculosis – Chemotherapy ordered. ☐ NO ☐ YES _____ Date

(Continued on Back)

## 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 effect 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 & Gingiva | | | | |
| • Lymph Glands | | | | |
| • Heart – Murmur, etc. | | | | |
| • Lung – Adventitious Findings | | | | |
| • Abdomen | | | | |
| • Genitourinary | | | | |
| • Neuromuscular System | | | | |
| • Extremities | | | | |
| • Spine (Presence of Scoliosis) | | | | |

Date of Examination

FAX TO SCHOOL NURSE
610-838-7429

Signature of Examiner

**PRINT** Name of Examiner

Address

Telephone Number