

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 <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

**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