



North Allegheny School District

Private Physician's Report of Physical Examination of School-Aged Student

PARENT/GUARDIAN SECTION (LINES 1, 2, 3, and 4):

1. Student's Full Name: _____ Date of Birth: _____
2. School: _____ / To be completed by NASD: **Grade:** _____ **Section:** _____ **ID#** _____
3. Father's Full Name: _____ Mother's Full Name: _____
4. Preferred Phone # (Home): _____ (Cell): _____ (Work): _____

PHYSICIAN SECTION (LINES 5, 6, 7, 8, and 9):

5. **IMMUNIZATION:** PROVIDE DATES OF ANY BOOSTERS GIVEN AFTER BASIC SERIES OR ON DAY OF EXAM IF NOT INCLUDED IN FILE

DTAP Date _____; MMR #1 Date _____ #2 Date _____ Chicken Pox - Date of Disease _____

Varicella Vaccine #1 Date _____ #2 Date _____; Lead #1 Date _____ #2 Date _____

Other _____ Date _____; ***Grades 7 – 12 -- in addition:**

Other _____ Date _____; 7th grade students must have completion of Tdap and 1st dose of MCV
12th grade students must have Tdap and completion of 2nd dose of MCV

6. **MEDICAL HISTORY:**

Allergies (please specify): _____

Hospitalizations/Surgery/Accidents/Serious Illness: (please specify)

(DATE) _____ (DATE) _____

7. **REPORT OF EXAMINATION:** * Please elaborate below on "abnormal" findings.

	NORMAL	ABNORMAL		NORMAL	ABNORMAL		NORMAL	ABNORMAL
General Nutrition			Glands			Skeleton		
Skin			Heart			Scoliosis- Bending Position		
Eyes			Lungs			Emotional Status		
Ears			Abdomen			Height _____ Weight _____		
Nose & Throat			Genitalia			BP _____ Pulse _____		
Teeth & Gingiva			Neuro Muscular System			**REQUIRED FOR ENTRANCE TO KDG: Distance: R 20/____ L 20/____ Near: R 20/____ L 20/____ Wears Corrective Lens: Yes ____ No ____		
*Abnormal findings: _____								

8. **RESTRICTIONS:** Should this child have restrictions on play or physical education activities? NO ____ YES ____ If "YES", please explain:

9. **RECOMMENDATIONS:** What recommendations do you wish to make to the teacher or School Nurse, which might be of benefit to this child?

DATE OF EXAMINATION: _____ PHYSICIAN'S NAME: _____
(Please print Physician's name)



SIGNATURE OF PHYSICIAN, CRNP, or PA: _____
(Signature of Physician, CRNP, or PA)

PHYSICIAN'S ADDRESS: _____ PHONE # _____