

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTHPRIVATE 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
_____	_____	_____	_____	☐ M ☐ F
Last	First	Middle		

ADDRESS

No. and Street	City or Post Office	Borough or Township	County	State	Zip Code
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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. _____
DateResult of Diagnostic Studies: _____
DatePreventive Anti-Tuberculosis - Chemotherapy ordered. ☐ No ☐ Yes _____
Date

(Continued on Back)

Brecknock Elementary School
T: 610-775-5079 F: 610-288-0584Mifflin Park Elementary School
T: 610-288-0570 F: 610-288-0579Middle School
T: 610-775-1465 F: 610-288-0595Cumru Elementary School
T: 610-775-5081 F: 610-288-0580Intermediate School
T: 610-775-5083 F: 610-288-0202High School
T: 610-775-5089 F: 610-288-0110

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 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