

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 |
| <div style="display: flex; justify-content: space-between; font-size: small;"> Last First Middle </div> | | |

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 | | | | |
| 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

(Continued on Back)

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