

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			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

(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