DUE WITHIN 30 DAYS OF BEGINNING SCHOOL FOR GRADES K, 6, AND 11 AND ALL STUDENTS NEW TO PENNSYLVANIA SCHOOLS.

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 ____

Last	First	Middle	AGE	SEX ☐ M ☐ F

ADDRESS

# and Street	City or Post Office	Borough or Township	County	State	Zip Code

MEDICAL HISTORY
IMMUNIZATIONS AND TESTS

(enter month/day/year each immunization was given)

VACCINE	DOSES			BOOSTERS	
Diptheria and Tetanus*	1.	2.	3.	4th dose after 4th birthday 4.	5.
Polio – Oral	1.	2.	3.		
Polio – Salk	1.	2.	3.	4.	
Measles, Mumps, Rubella (or evidence of blood test proving immunity; or signed physician statement child had disease)	1.	2.			
Hepatitis B (required for students new to PA, K, grade 7)	1.	2.	3.		
HIB	1.	2.	3.		
Varicella OR	1.				
Date of Chickenpox Disease	1.				
Other (please specify)					
*Diptheria and Tetanus are usually received in combination vaccines as DTP, DT, of Td					

☐ 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)

Tuberculin Test Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	/ /	Results (mm)		Signature	

Followup of significant tuberculin tests:

Parent/Guardian notified of significant findings on _____/_____/_____

Results of Diagnostic Studies: _____

Preventive Anti-Tuberculosis – Chemotherapy ordered. ☐NO ☐ Yes ____/____/____

NOTE: A physical examination must be done not more than one year prior to school to be acceptable.

Significant Medical Conditions

	Yes	No	If yes, please 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 (please specify) _____

Report of Physical Examination

	Normal	Abnormal	If abnormal, please explain
Height (in inches) _____			
Weight (in lbs) _____			
Pulse (_____)			
Blood Pressure _____/_____			
Hair/Scalp			
Skin			
Eyes – Color			
Eyes – Vision			
Eyes – Visual Acuity R ___/___			
Eyes – Visual Acuity L ___/___			
Ears – Hearing dB R L			
Nose and Throat			
Teeth and Gingiva			
Lymph Glands			
Heart – murmur, etc			
Lungs – Adventious Findings			
Abdomen			
Genitalia			
Neuromuscular System			
Extremities			
Spine (presence of scoliosis)			
Sports/Physical Activity Restriction	☐ No	☐ Yes	

Date of Examination _____/_____/_____

Please Print:
Name of Examiner _____
Address _____
Telephone Number _____

_____
Signature of Examiner
9/26/02