

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
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				
	DOSES				
	BOOSTERS & DATES				
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

**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