

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

AGE

SEX

☐
M☐
F

Last

First

Middle

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*	1 / /	2 / /	3 / /	4 / /	5 / /
Polio	1 / /	2 / /	3 / /	4 / /	5 / /
Measles, Mumps, Rubella	1 / /	2 / /			
Hepatitis B	1 / /	2 / /		3 / /	
HIB	1 / /	2 / /		3 / /	
Other <u>Varicella</u>					

* Tetanus and Diphtheria are usually received in combined vaccines such as DTP, DT, or Td

☐ MEDICAL EXEMPTION

The physical condition of the above named child is such that immunization would endanger life or health

☐ RELIGIOUS EXEMPTION

(Include a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian.)

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"/>	

Report of Physical Examination (✓)

	Normal	Abnormal	If Abnormal, Explain
● Height (inches)			
● Weight (pounds)			
● Pulse ()			
● Blood Pressure /			
● Hair/Scalp			
● Skin			
● Eyes — Visual Acuity R___/___ L___/___			
● Eyes — Color Vision			
● Ears — Hearing dB R L			
● Nose and Throat			
● Teeth and Gingiva			
● Lymph Glands			
● Heart — Murmur, etc.			
● Lung — Adventitious Findings			
● Abdomen			
● Genitalia			
● Neuromuscular System			
● Extremities			
● Spine (Presence of Scoliosis)			

Date of Examination _____

Signature of Examiner _____

Print Name of Examiner _____

Address _____