

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF HEALTH

**PRIVATE PHYSICIAN'S REPORT OF  
PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE**

DATE \_\_\_\_\_ 19 \_\_\_\_\_

NAME OF SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_ HOMEROOM \_\_\_\_\_

NAME OF CHILD  _____	AGE  _____	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
----------------	---------------------	---------------------	--------	-------	----------

**MEDICAL HISTORY  
IMMUNIZATIONS AND TESTS**

VACCINE	Enter Month, Day, And Year Each Immunization Was Given				
	DOSES			BOOSTERS & DATES	
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 _____					

\* 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 \_\_\_\_\_

**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 \_\_\_\_\_