

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<br><br>_____   | DATE OF BIRTH<br><br>_____ | SEX<br><input type="checkbox"/> M <input type="checkbox"/> F |
| <div style="display: flex; justify-content: space-between; font-size: small;"> <span>Last</span> <span>First</span> <span>Middle</span> </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 |       |       |  |       |
|---|--|-------|-------|--|-------|
|   | DOSES  |       |       | BOOSTERS & DATES                                 |       |
| Diphtheria and Tetanus<br>(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<br>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<br>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