

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
<div style="display: flex; justify-content: space-between; font-size: small;"> Last First Middle </div>		

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			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 _____					

* 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