H511.336 (Rev. 6/97)

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 |
|---|---|---|
| _____ Last First Middle | | ☐ M ☐ F |

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

(Continued on Back)

## Significant Medical Conditions (✓)

| | Yes | No | If Yes, Explain |
|---|---|---|---|
| Allergies | ☐ | ☐ | |
| Asthma | ☐ | ☐ | |
| Cardiac | ☐ | ☐ | |
| Chemical Dependency | ☐ | ☐ | |
| Drugs | ☐ | ☐ | |
| Alcohol | ☐ | ☐ | |
| Diabetes Mellitus | ☐ | ☐ | |
| Gastrointestinal Disorder | ☐ | ☐ | |
| Hearing Disorder | ☐ | ☐ | |
| Hypertension | ☐ | ☐ | |
| Neuromuscular Disorder | ☐ | ☐ | |
| Orthopedic Condition | ☐ | ☐ | |
| Respiratory Illness | ☐ | ☐ | |
| Seizure Disorder | ☐ | ☐ | |
| Skin Disorder | ☐ | ☐ | |
| Vision Disorder | ☐ | ☐ | |
| Other (Specify) | ☐ | ☐ | |

## 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 — Adventious Findings | | | |
| • Abdomen | | | |
| • Genitalia | | | |
| • Neuromuscular System | | | |
| • Extremities | | | |
| • Spine (Presence of Scoliosis) | | | |

Date of Examination

Signature of Examiner

Print Name of Examiner

Address