COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF HEALTH

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

										DA	ATE.						20	
NAME OF SCHOOL									GRADE					_ HOMEROOM				
NAME OF CHILD													DATE OF BIRTH				SEX	
																		M F
Last				F	irst					Middle	:							
ADDRESS																		
No. and Street				City or Post Office				Borough or Township			County				State Zip Code			
				1		DICA				rs								
VACCIA	Enter Month, Day, And Year Given									s		BOOSTERS & DATES						
VACCINE Diphtheria and Tetanus			1,			2	/		3			/	4	,	<u> </u>	5	<u> </u>	/
(Circle): DTaP, DTI		T, Td	1	,	,		,											
Polio (Circle): OPV,	IPV		1	/	/	2	1	/	Э	/		/	4	j	1	5	1	
Measles, Mumps, Rubella				1	1	2	/	/										
Hepatitis B			1		1	1		2		/		1		3		/		f
HIB			1		1	1		2		/		1		3		Į.		1
Varicella			1 / /				2 / /				Varicella Disease or Lab Evidence							
													Date:					
Other TDaP:							MENINGIT			TIS:	S:							
MEDICAL EXEMPT	ION	The phys	J ical cor	ndition	of the ab	ove named	child	is such th	L nat im:	muniz	ation	would e	endange	er life o	r health			
RELIGIOUS EXEM	PTIO	V (Includes	a stron	na moi	ral or ethic	al convicti	an sim	nilar to a r	eliaiou	ıs beli	ief and	d requir	es a wri	tten sta	itement	from the	e pare	nt/quardia
	11101	• (Includes	a suor	ig moi	a or enic	ar correct	JII 3.11		ongio	20 001							, ,	
f Applicable:																		
Tuberculin Tests Arm Date Applied		Device			ce	e			Antigen		Manufac		turer Sign		gna	nature		
Date Read	Results				s (mm)							s	ignat	ure				
Treatile (IIII)						I						9						
Follow-Up of significa	nt tub	erculin te	ests:															
Parent/Guardian notif	ied of	significa	nt find	ding	s on.			Date	-		-							
Result of Diagnostic S	Studie	es:				Date												
Preventive Anti-Tuber	culos	is - Chem	othe	rapy	ordere	ed. [) o	Yes	De	ate								

(Continued on Back)

				fedical Cond	itions (√)	
Alloraico	Yes	No	If Yes, E	xplain		
Allergies	H	Н				
Cardiac	Ħ	H				
Chemical Dependency	\Box	ō				
Drugs						
Alcohol						
Diabetes Mellitus	Ц					
Gastrointestinal Disorder						
Hearing Disorder	H	H				
Hypertension Neuromuscular Disorder	H	H				
Orthopedic Condition	Ī	П				
Respiratory Illness						
Seizure Disorder						
Skin Disorder						AND SOLVE TO
Vision Disorder	Ц					
Other (Specify)				Name of the second		
Are there any special medical prob	olems (or chr	onic dis	seases which	require restriction	of activity, medication or which
might affect his/her education? If so,						
Report of Physical Examination	1.4					
neport of Physical Examination	(*)					_
		No	rmal	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)		<u> </u>				
Date of Examination						
Signature of Examiner					Drine Now	ne of Examiner
· ·					Frint Nam	ie or Examiner
Address					Telephone	Number