

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

DATE _____ 20____

NAME OF SCHOOL _____ GRADE _____ HOMEROOM _____

| | | | | |
|---------------|-------|--------|---------------|----------------------------------------------------------|
| NAME OF CHILD | | | DATE OF BIRTH | SEX |
| Last | First | Middle | | <input type="checkbox"/> M <input type="checkbox"/> 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 (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 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 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 _____.

Result of Diagnostic Studies: _____

Preventive Anti-Tuberculosis – Chemotherapy ordered. No Yes _____ Date

Significant Medical Conditions (√)
If Yes, Explain

| | Yes | No | |
|--------------------------------|--------------------------|--------------------------|-------|
| 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 Finding | | | | |
| ▪ Abdomen | | | | |
| ▪ Genitourinary | | | | |
| ▪ Neuromuscular System | | | | |
| ▪ Extremities | | | | |
| ▪ Spine (Presence of Scoliosis) | | | | |

Date of Examination

Signature of Examiner

PRINT Name of Examiner

Address

Telephone Number