

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;"> <span>Last</span> <span>First</span> <span>Middle</span> </div>		

ADDRESS

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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 Give			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 / /	4 / /	5 / /
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 (X)**

	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			
• 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