

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

DATE \_\_\_\_\_ 20 \_\_\_\_\_

NAME OF SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_ HOMEROOM \_\_\_\_\_

<b>NAME OF CHILD</b>			<b>DATE OF BIRTH</b>	<b>SEX</b>
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
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**MEDICAL HISTORY IMMUNIZATIONS AND TESTS**

VACCINE	Enter Month, Day, and Year each immunization was given <b>DOSES</b>			<b>BOOSTERS &amp; DATES</b>	
	1	2	3	4	5
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, TD	/ /	/ /	/ /	/ /	/ /
Polio (Circle): OPV, IPV	/ /	/ /	/ /	/ /	/ /
Measles, Mumps, Rubella	/ /	/ /			
Hepatitis B	/ /	/ /	/ /	/ /	/ /
HIB	/ /	/ /	/ /	/ /	/ /
Varicella	/ /	/ /	/ /	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