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**		☐ ☐ **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 (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)

<u>If Applicable:</u>

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	☐	☐	
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)	☐	☐	

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**