

**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 |          |  | BOOSTERS & DATES |          |
|---|--|----------|--|------------------|----------|
|   | DOSES  |          |  |                  |          |
| Diphtheria and Tetanus<br>(Circle): DTaP, DTP, DT, TD | 1<br>/ /   | 2<br>/ / | 3<br>/ /   | 4<br>/ /         | 5<br>/ / |
| Polio (Circle): OPV, IPV                              | 1<br>/ /   | 2<br>/ / | 3<br>/ /   | 4<br>/ /         | 5<br>/ / |
| Measles, Mumps, Rubella                               | 1<br>/ /   | 2<br>/ / |  |                  |          |
| Hepatitis B   | 1<br>/ /   | 2<br>/ / | 3<br>/ /   |                  |          |
| HIB   | 1<br>/ /   | 2<br>/ / | 3<br>/ /   |                  |          |
| Varicella   | 1<br>/ /   | 2<br>/ / | Varicella Disease or Lab Evidence<br>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<br>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