

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 <input type="checkbox"/> M <input type="checkbox"/> F
_____ Last	_____ First	_____ Middle		

ADDRESS _____

No. and Street	City or Post Office	Borough or Township	County	State	Zip Code
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IMMUNIZATIONS AND TESTS

VACCINE	Enter Month, Day, and Year Each Immunization Was Given, Including Boosters DOSES				
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, Td <i>Four doses required, with one dose given @ age 4 years or older.</i>	1. / /	2. / /	3. / /	4. / /	5. / /
Tetanus, Diphtheria, and Acellular Pertussis (Adacel, Boostrix, Tdap) <i>One dose required for students entering 7th grade.</i>	1. / /				
Polio (Circle) : OPV, IPV <i>Three doses are required</i>	1. / /	2. / /	3. / /	4. / /	5. / /
Hepatitis B: Three properly spaced doses are required.	1. / /	2. / /	3. / /		
Measles, Mumps, Rubella: Two doses of measles; two doses of mumps, one dose of rubella required. First dose must be given after age one year.	1. MMR: / /	2. MMR: / /	Measles only:	Mumps only:	
Varicella Vaccine or Disease: Two doses required; or date or age of disease; or lab evidence. First dose must be given after age one year.	1. / /	2. / /	Varicella Disease: Age or Date: _____ Lab Evidence: Date: _____ Results: _____		
Meningococcal Conjugate (MCV4): <i>One dose required for students entering 7th grade.</i>	1. / /				
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. _____
DateResults of Diagnostic Studies: _____
DatePreventive Anti-Tuberculosis – Chemotherapy ordered. ☐ NO ☐ YES _____
Date

Significant Medical Conditions (✓)

	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"/>	

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might effect 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 & Gingiva				
• Lymph Glands				
• Heart – Murmur, etc.				
• Lung – Adventitious Findings				
• Abdomen				
• Genitourinary				
• Neuromuscular System				
• Extremities				
• Spine (Presence of Scoliosis)				

Date of Examination

Signature of Examiner

PRINT Name of Examiner

Address

Telephone Number