H511.336 (Rev 5/02)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

DATE ______________ 20_______

NAME OF SCHOOL ____ GRADE _____ HOMEROOM _______

NAME OF CHILD ____ Last First Middle	DATE OF BIRTH	SEX ☐ ☐ 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)

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	☐	☐	____
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