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	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)

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
③ Height (inches)				
③ Weight (pounds) BMI				
③ Pulse ( )				
③ Blood Pressure				
③ Hair/Scalp				
③ Skin				
③ Eyes/Vision				
③ Ears/Hearing				
③ Nose and Throat				
③ Teeth and Gingiva				
③ Lymph Glands				
③ Heart – Murmur, etc				
③ Lung – Adventitious Finding				

③ Abdomen				
③ Genitourinary				
③ Neuromuscular System				
③ Extremities				
③ Spine (Presence of Scoliosis)				

_____

Date of Examination

_____ _____

Signature of Examiner **PRINT** Name of Examiner

_____ _____

Address Telephone Number