

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

DATE _____ 19____

NAME OF SCHOOL _____ GRADE _____ HOMEROOM _____

NAME OF CHILD _____ AGE _____ SEX

M F

Last First Middle

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	
	1	2	3	4	5	6	7
Diphtheria and Tetanus*	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Polio	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Measles, Mumps, Rubella	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Hepatitis B	/ /	/ /	/ /	/ /	/ /	/ /	/ /
HIB	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Other <u>Varicella</u>	/ /	/ /	/ /	or disease	/ /	/ /	/ /

* Tetanus and Diphtheria are usually received in combined vaccines such as DTP, DT, or TD

- MEDICAL EXEMPTION** The physical condition of the above named child is such that immunization would endanger life or health
- RELIGIOUS EXEMPTION** (Include a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian.)

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 _____
Date

Result of Diagnostic Studies: _____
Date

Preventive 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"/>	_____

Report of Physical Examination (√)

	Normal	Abnormal	If Abnormal, Explain
● Height (inches)			
● Weight (pounds)			
● Pulse ()			
● Blood Pressure /			
● Hair/Scalp			
● Skin			
● Eyes --- Visual Acuity R / L /			
● Eyes --- Color Vision			
● Ears --- Hearing dB R L			
● Nose and Throat			
● Teeth and Gingiva			
● Lymph Glands			
● Heart --- Murmur, etc.			
● Lung --- Adventitious Findings			
● Abdomen			
● Genitalia			
● Neuromuscular System			
● Extremities			
● Spine (Presence of Scoliosis)			

Date of Examination

Signature of Examiner

Print Name of Examiner

Address