**Council Rock School District**
**Bucks County Pennsylvania**

# 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

_____ _____ 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 & year each immunization was given DOSES | | | BOOSTERS & DATES | | |
|---|---|---|---|---|---|---|
| Diphtheria and Tetanus (circle): DTaP, DTP, DT, TD | 1 / / | 2 / / | 3 / / | 4 / / | 5 / / | Tdap 7th gr 2011-12 (new requirement) / / |
| Polio (circle): OPV, IPV | 1 / / | 2 / / | 3 / / | 4 / / | 5 / / | |
| MMR 1st dose after 1 yr of age | 1 / / | 2 / / | | | | |
| Measles 1st dose after 1 yr of age | 1 / / | 2 / / | | | | |
| Mumps 1st dose after 1 yr of age | 1 / / | 2 / / (new requirement 2011) | | | | |
| Rubella after 1 yr of age | 1 / / | | | | | |
| Hepatitis B | 1 / / | 2 / / | 3 / / | | | |
| Hepatitis A | 1 / / | 2 / / | 3 / / | | | |
| HIB | 1 / / | 2 / / | 3 / / | | | |
| Varicella | 1 / / | 2 / / (2011-2012 new requirement) | Varicella Disease or Lab Evidence Date: _____ | | | |
| Entering 7th grade 2011-12 Meningococcal Conjugate (MCV) | | 1 / / (2011-2012 new requirement) | | | | |
| Other | 1 / / | 2 / / | 3 / / | | | |

☐ MEDICAL EXEMPTION The physical condition of the above named child is such that immunization would endanger life or health.

☐ RELIGIOUS EXEMPTION A strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent or 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_____ (Date)
Result of Diagnostic Studies: _____ (Date)
Preventive Anti-Tuberculosis – Chemotherapy ordered: NO YES _____ (Date)

**Significant Medical Conditions (√)**

| | Yes | No | If Yes, Explain |
|---|---|---|---|
| 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 Findings | | | | |
| • Abdomen | | | | |
| • Genitourinary | | | | |
| • Neuromuscular System | | | | |
| • Extremities | | | | |
| • Spine (Presence of Scoliosis) | | | | |

_____
Date of Examination

_____ _____
Signature of Examiner **Print** Name of Examiner

_____ _____
Address Telephone Number