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 & 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 _____
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