

**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

ADDRESS \_\_\_\_\_  
Last First Middle

\_\_\_\_\_ 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			BOOSTERS & DATES		
	DOSES					
Diphtheria and Tetanus (circle): DTaP, DTP, DT, TD	1 / /	2 / /	3 / /	4 / /	5 / /	Tdap 7 <sup>th</sup> gr / /
Polio (circle): OPV, IPV	1 / /	2 / /	3 / /	4 / /	5 / /	
MMR 1 <sup>st</sup> dose after 1 yr of age	1 / /	2 / /				
Measles 1 <sup>st</sup> dose after 1 yr of age	1 / /	2 / /				
Mumps 1 <sup>st</sup> dose after 1 yr of age	1 / /	2 / /				
Rubella after 1 yr of age	1 / /					
Hepatitis B	1 / /	2 / /		3 / /		
Hepatitis A (not required)	1 / /	2 / /		3 / /		
HIB (not required)	1 / /	2 / /		3 / /		
Varicella	1 / /	2 / /			Varicella Disease or Lab Evidence Date: _____	
Entering 7 <sup>th</sup> grade: Meningococcal Conjugate (MCV)		1 / /				
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	<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"/>	_____

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