

10<sup>th</sup> Grade Parents

Any physical exam done after 9/1/11 will qualify as the 11<sup>th</sup> grade physical exam.

HS11.938 (Rev. 5/02)

**PLEASE MAKE A COPY OF ALL FORMS RETURNED TO THE SCHOOL NURSE**

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
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
<small>Last</small>	<small>First</small>	<small>Middle</small>		

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				
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 \_\_\_\_\_

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