

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

DATE _____ 20 _____

NAME OF SCHOOL _____ GRADE _____ HOMEROOM _____

NAME OF CHILD _____	AGE _____	SEX <input type="checkbox"/> M <input type="checkbox"/> F
Last _____	First _____	Middle _____

ADDRESS _____

No. and Street	City or Post Office	Borough or Township	County	State
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Zip Code _____

**MEDICAL HISTORY
IMMUNIZATIONS AND TESTS**

VACCINE	Enter Month, Day, And Year Each Immunization Was Given			BOOSTERS & DATES	
	DOSES				
Diphtheria and Tetanus*	1 / /	2 / /	3 / /	4 / /	5 / /
Polio	1 / /	2 / /	3 / /	4 / /	5 / /
Measles, Mumps, Rubella	1 / /	2 / /			
Hepatitis B	1 / /		1 / /		1 / /
HIB	1 / /		1 / /		1 / /
Other _____					

* 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 Dates 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

Preventative Anti-Tuberculosis - Chemotherapy ordered. No Yes Date

Significant Medical Conditions (4)

	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 (4)

Normal Abnormal If Abnormal, Explain

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

Date of Examination

Signature of Examiner

Print Name of Examiner

Address