H511.336 (Rev. 9/89)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

NAME OF SCHOOL _____ DATE _____ 19 ____

NAME OF CHILD			AGE	SEX	HEIGHT	WEIGHT
Last	First	Middle		☐ M ☐ F	INS.	LBS.

ADDRESS

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

MEDICAL HISTORY

IMMUNIZATIONS AND TESTS

The Minimum Required Doses for the School Immunization Law are Shaded in Green (see exception for Polio)

VACCINE	ENTER MONTH, DAY, AND YEAR EACH IMMUNIZATION WAS GIVEN — DOSES				
Diphtheria and Tetanus*	1 / /	2 / /	3 / /	4 / /	5 / /
Polio**	1 / /	2 / /	3 / /	4 / /	5 / /
Measles (Hard, Red)	1 / /	or Measles Serology: Date _____ Titer ____: _____			
Rubella (German Measles)	1 / /	or Rubella Serology: Date _____ Titer ____: _____			
Mumps	1 / /	or Mumps disease diagnosed by a physician Date _____			
Other: / /	Other: / /	Other: / /			

** Tetanus and Diphtheria are usually received in combined vaccines such as DTP, DT, or Td*
*** Polio — 3 doses of Oral or 4 doses of Inactivated (Salk) vaccine are required*

☐ 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.

Tuberculin Tests Date Applied	Arm	Device	Antigen	Lot #	Manufac	Signature
Date Read	**Results (mm)**		Signature			

Follow-Up of significant tuberculin tests

Parent/Guardian notified of significant findings on _____.
Date

Result of Diagnostic Studies: _____.

Preventive Anti-Tuberculosis - Chemotherapy ordered.

☐ _____ ☐ _____
No Date **Yes** Date

(Continued on Back)

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)	☐	☐	

Report of Physical Examination (✓)

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

Date of Examination

Signature of Examiner

Print Name of Examiner

Address