

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

DATE: _____ 200
M D Y
NAME OF SCHOOL: **HOPE Charter High School** GRADE: _____

NAME OF CHILD: _____ DATE OF BIRTH: _____
M D Y
SEX: M F

ADDRESS: _____
Philadelphia Pa 191
No. and street City State ZIP

**MEDICAL HISTORY
IMMUNIZATIONS AND TESTS**

VACCINE	Enter month, day and Year each immunization was given			BOOSTERS & DATES	
	DOSES				
Diphtheria & 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 student 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 parent/guardian)

If applicable:

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

Preventive Anti-Tuberculosis – chemotherapy ordered No Yes _____
date

(continued on back)

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 this student's education? Of so, please specify: _____

REPORT OF PHYSICAL EXAMINATION (please check)

	Normal	Abnormal	Not examined	Comments
Height (inches)				
Weight (lbs)				
Pulse				
Blood pressure				
Hair/scalp				
Skin				
Eyes/vision				
Ears/hearing				
Nose/throat				
Teeth & Gingiva				
Lymph glands				
Hear – murmur etc				
Lung – adventitious findings				
Abdomen				
Genito-urinary				
Neuromuscular system				
Extremities				
Spine (presence of Scoliosis)				

_____ date of examination

_____ signature of examiner

_____ **PRINT** name of examiner

_____ address

_____ tel no.