H511.336 (Rev 5/02)

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
Last	First	Middle		☐ M ☐ F

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			BOOSTERS & DATES	
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: _____					

2 Step Tuberculin Test – TWO SEPARATE INJECTIONS - TWO SEPARATE READINGS

FIRST Tuberculin Test Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	Results (mm)		Signature		
SECOND Tuberculin Test 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 _____.

Result of Diagnostic Studies: _____.
Preventive Anti-Tuberculosis – Chemotherapy ordered. ☐ No ☐ Yes _____ Date

Significant Medical Conditions (√)
If Yes, Explain

	Yes	No	
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)	☐	☐	
		☐	

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 Finding				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Presence of Scoliosis)				

_____
Date of Examination

_____ _____
Signature of Examiner PRINT Name of Examiner

_____ _____
Address Telephone Number