

**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		<input type="checkbox"/> M <input type="checkbox"/> F

ADDRESS

No. and Street	City or Post Office	Borough or Township	County	State	Zip Code
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**MEDICAL HISTORY
IMMUNIZATIONS AND TESTS**

VACCINE	Enter Month, Day, and Year each immunization was given DOSES			BOOSTERS & DATES	
	1	2	3	4	5
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, TD	/ /	/ /	/ /	/ /	/ /
Polio (Circle): OPV, IPV	/ /	/ /	/ /	/ /	/ /
Measles, Mumps, Rubella	/ /	/ /			
Hepatitis B	/ /	/ /	/ /	/ /	/ /
HIB	/ /	/ /	/ /	/ /	/ /
Varicella	/ /	/ /	/ /	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 _____.

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

Significant Medical Conditions (√)

If Yes, Explain

	Yes	No	
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 Finding				
▪ Abdomen				
▪ Genitourinary				
▪ Neuromuscular System				
▪ Extremities				
▪ Spine (Presence of Scoliosis)				

Date of Examination

Signature of Examiner

PRINT Name of Examiner

Address

Telephone Number

ACT OF GENERAL ASSEMBLY NO. 434

Section 1407. Examinations by Examiners of Own Choice

In lieu of the medical or dental examinations prescribed by this article, any child of school age may furnish the local school officials with a medical or dental report of examination made at his own expense by his family physician or family dentist on a form approved by the Secretary of Health for this purpose. The "in lieu" examinations shall be made and the report shall be furnished prior to the date fixed for the regularly scheduled examination, but not earlier than one (1) year prior to the opening of the school term during which the regular examination is scheduled.

NOTE: IF CHILD HAS BEEN EXAMINED NO EARLIER THAN 1 YEAR PRIOR TO THE OPENING OF THE SCHOOL TERM DURING WHICH THE REGULAR EXAMINATION IS SCHEDULED, THE FAMILY DENTIST MAY SUPPLY THE REQUESTED INFORMATION FROM HIS OFFICE RECORDS. IF THE CHILD HAS NOT BEEN EXAMINED WITHIN 1 YEAR OF THE OPENING OF THE SCHOOL TERM, A NEW EXAMINATION WILL BE REQUIRED.

Please have the lower portion completed by your family dentist, and returned to the school nurse.

Middletown Area School District

School Health Services - Family Dentist Report

Building _____ Grade _____

Name _____
First Name Middle Name Last Name

The above named child last visited my office on _____
Date of Visit

At that time, all necessary dental corrections had been made: Yes No

If the answer is no, fill in the following:

This child is currently under treatment: Yes No

Signature of D.D.S/D.M.D. _____ Date _____

Address _____
Street City State Zip Code