PRIVATE PHYSICIAN'S REPORT OF

PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE

Date_____

SCHOOL_____GRADE_____HOMEROOM_____

NAME OF CHILD

M F

Last First Middle I Date of Birth Sex

ADDRESS

No. and Street City or Post Office State Zip Code

IMMUNIZATIONS

VACCINE	Enter Month, Day, and Year each immunization was given.				BOOSTERS AND DATES
Diphtheria and Tetanus (Circle) DTaP, DTP, DT, TD	1. / /	2. / /	3. / /	4. / /	5. / /
Tetanus, Diphtheria, Adelluar Pertussis--(Tdap)	1 / /	2. / /			
Polio (OPV- IVP)	1. / /	2. / /	3. / /	4. / /	5. / /
Hepatitis B	1. / /	2. / /	3. / /	Other	
Measles-Mumps-Rubella (MMR)	1. / /	2. / /	Measles Serology Date -Titre		
Varicella (Vaccine or Disease)	1. / /	2. / /	Rubella Serology Date - Titre		
Meningococcal (MCV)	1. / /	2. / /	Other		
Human Papilloma Virus (HPV)	1. / /	2. / /	3. / /		
Hepatitis A (Hep A)	1. / /	2. / /	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)

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