


This form is **REQUIRED** only for students in their first year of school (either Kindergarten or 1st Grade), in 6th Grade, and in 11th Grade.

Commonwealth of Pennsylvania
Department of Health

Health Form: Medical

Private Physician's Report of Physical Examination of a Student of School Age

Name of Child	First	Middle	Last	DOB	Month	Day	Year
	 Central Pennsylvania Digital Learning Foundation				AGE	SEX	M
Name of School						GRADE	
Child's Address	Address City or Post Office Borough or Township County State Zip						

Medical History

Immunizations and Tests

Vaccine	Doses					Boosters & Dates									
	Enter month, day and year each Immunization was given														
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, Td	1	/	/	2	/	/	3	/	/	4	/	/	5	/	/
Polio (Circle): OPV, IPV	1	/	/	2	/	/	3	/	/	4	/	/	5	/	/
Measles, Mumps and 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 the above named child is such that immunization would endanger life or health.
- Religious Exemption**
Include a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/legal guardian.

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

Significant Medical Conditions

			<i>If yes, explain</i>
Allergies	<input type="radio"/> Yes	<input type="radio"/> No	_____
Asthma	<input type="radio"/> Yes	<input type="radio"/> No	_____
Cardiac	<input type="radio"/> Yes	<input type="radio"/> No	_____
Chemical Dependency	<input type="radio"/> Yes	<input type="radio"/> No	_____
Drugs	<input type="radio"/> Yes	<input type="radio"/> No	_____
Alcohol	<input type="radio"/> Yes	<input type="radio"/> No	_____
Diabetes Mellitus	<input type="radio"/> Yes	<input type="radio"/> No	_____
Gastrointestinal Disorder	<input type="radio"/> Yes	<input type="radio"/> No	_____
Hearing Disorder	<input type="radio"/> Yes	<input type="radio"/> No	_____
Hypertension	<input type="radio"/> Yes	<input type="radio"/> No	_____
Neuromuscular Disorder	<input type="radio"/> Yes	<input type="radio"/> No	_____
Orthopedic Condition	<input type="radio"/> Yes	<input type="radio"/> No	_____
Respiratory Illness	<input type="radio"/> Yes	<input type="radio"/> No	_____
Seizure Disorder	<input type="radio"/> Yes	<input type="radio"/> No	_____
Skin Disorder	<input type="radio"/> Yes	<input type="radio"/> No	_____
Vision Disorder	<input type="radio"/> Yes	<input type="radio"/> No	_____
Other (specify)	<input type="radio"/> Yes	<input type="radio"/> No	_____

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might effect his/her education? If so, specify. _____

Report of Physical Examination

	Normal	Abnormal	Not Examined	Comments
Height (inches)				
Weight (pounds)				
Pulse ()				
Blood Pressure /				
Hair/Scalp				
Skin				
Eyes NEAR Visual Acuity R___/___ L___/___				
Eyes FAR Visual Acuity R___/___ L___/___				
Eyes - Plus Lens / Color / Stereopsis				
Ears - Hearing dB R L				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart - Murmur, etc.				
Lung - Adventitious Findings				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Presence of Scoliosis)				

Signature of Examiner

Print Name of Examiner

Date of Examination

Address

