

REPORT OF PHYSICAL EXAMINATION

Name of School	Student ID		
Name of Student	Date of Birth	Room/Section/Book	

TO THE CARE PROVIDER

Pennsylvania law requires that students attending school in the Commonwealth be immunized and receive periodic medical examinations at stated intervals. Participation in sports also requires a physical examination. Payment for these examinations is the responsibility of the parent. Both sides of form must be completed for sports participation.

THESE IMMUNIZATIONS ARE REQUIRED FOR SCHOOL ATTENDANCE. Attach a copy of the student's immunization record, or record the dates below. Minimum required doses for **Pennsylvania School Law** are shaded.

VACCINE	Enter Month, Day, and Year Each Immunization Was Given DOSES (SEE ATTACHED)				
Diphtheria and Tetanus* (DTap, DTP, Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /
Polio, (OPV or IPV)	1 / /	2 / /	3 / /	4 /	
HepatitisB	1 / /	2 / /	3 / /		
Measles** - Mumps - Rubella (MMR)	1 / /	2 / /	or Measles Serology: Date Titer		
Varicella	1 / /	2 / /	Rubella Serology: Date Titer		
Other	1 / /	2 / /	Mumps disease diagnosed by a physician: Date		

* One dose must be on or after the fourth birthday.

** First dose must be on or after the first birthday and the second dose should be at least one month after the first dose.

RECORD THE FOLLOWING

1. Visual Acuity (Far) R 20/ L 20/	(Near) R 20/ L 20/
2. Height" inches /cm Percentile	Weightlbs pounds / kg Percentile%
3. Scoliosis Screening Normal Abnormal	Referred No Referral
4. Blood Pressure Pulse	Audiometric Screening R passed Lpassed
5. Date of last PPD Result _____ mm	Date of last Tetanus Booster
6. List all medications currently being taken.	Reason for medication

7. Circle any condition this student has or ever had: allergy, asthma, bone fracture or dislocation, congenital abnormality, contacts or glasses, diabetes, epilepsy, head injury, hearing loss, heart trouble or murmur if any. Please specify details, under comments.

8. Has student ever had any serious illness, injury or operation? Yes No
If yes, please specify details.

9. List other problems at this history or examination	Status of the Problem		
	Under Care	Care is Complete	Referred
1.			
2.			
3.			

10. No problems identified

Comments / follow - up treatment plan / Special instructions to school

Signature of Care Provider (REQUIRED)	Telephone	Care Provider office stamp (REQUIRED)
Address	Date of Exam	