

COMMONWEALTH OF PENNSYLVANIA  
MIFFLIN COUNTY SCHOOL DISTRICT  
MANDATED PHYSICAL EXAMINATIONS  
Grades (K-6-1 1)

Dear Parent or Guardian:

The Pennsylvania School Health Law requires all children to have a physical exam upon original entry into school, in the 6<sup>th</sup> grade, and in the 11<sup>th</sup> grade. If your child gets a physical for any reason (example: routine physical, camp physical, worker's permit, or driver's license physical) please have the attached form completed by your physician. The completed form may be returned to the school office during the summer or the beginning of the school year. Physical exams may be obtained twelve (12) months prior to the required school year.

It is recommended that a family physician complete the examination report for school records because the physician has a good knowledge of your child's medical history.

School Nurse

**COMMONWEALTH OF  
PENNSYLVANIA  
DEPARTMENT OF HEALTH**

**PRIVATE PHYSICIAN'S REPORT OF  
PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL**

DATE \_\_\_\_\_ 20 \_\_\_\_\_

**NAME OF SCHOOL** \_\_\_\_\_ **GRADE** \_\_\_\_\_ **HOMEROOM** \_\_\_\_\_

<b>NAME OF CHILD</b>			<b>DATE OF BIRTH</b>	<b>SEX</b> <input type="checkbox"/> M <input type="checkbox"/> F
Last	First	Middle		

**ADDRESS**

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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					BOOSTERS & DATES
	DOSES					
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 _____						

- 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 \_\_\_\_\_ Date

Result of Diagnostic Studies: \_\_\_\_\_ Date

Preventive Anti-Tuberculosis - Chemotherapy ordered.     No     Yes    \_\_\_\_\_ Date

**Significant Medical Conditions**

	Yes	No	If Yes, Explain
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**

• 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 Findings				
• Abdomen				
• Genitourinary				
• Neuromuscular System				
• Extremities				
• Spine (Presence of Scoliosis)				

\_\_\_\_\_ Date of Examination

\_\_\_\_\_ Signature of Examiner

\_\_\_\_\_ Print Name of Examiner

\_\_\_\_\_ Address

\_\_\_\_\_ Telephone Number