

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 6th grade, and in the 11th 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** _____

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 _____

**MEDICAL HISTORY
IMMUNIZATIONS AND TESTS**

VACCINE	Enter Month, Day, And Year Each Immunization Was Given				
	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