

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

NAME OF SCHOOL _____ DATE _____ 19__

NAME OF CHILD			AGE	SEX	HEIGHT	WEIGHT
Last	First	Middle		<input type="checkbox"/> M <input type="checkbox"/> F	INS.	LBS.

ADDRESS

No. and Street	City or Post Office	Borough or Township	County	State	Zip
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**MEDICAL HISTORY
IMMUNIZATIONS AND TESTS**

The Minimum Required Doses for the School Immunization Law are Shaded in Green (see exception for Polio)

VACCINE	ENTER MONTH, DAY, AND YEAR EACH IMMUNIZATION WAS GIVEN				
	DOSES				
Diphtheria and Tetanus*	1	2	3	4	5
Polio**	1	2	3	4	5
Measles (Hard, Red)	1	or Measles Serology: Date _____ Titer _____:			
Rubella (German Measles)	1	or Rubella Serology: Date _____ Titer _____:			
Mumps	1	or Mumps disease diagnosed by a physician Date _____			
Other: / /	Other: / /	Other: / /			

* Tetanus and Diphtheria are usually received in combined vaccines such as DTP, DT, or Td
** Polio — 3 doses of Oral or 4 doses of Inactivated (Salk) vaccine are required

- 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.)

Tuberculin Tests Date Applied	Arm	Device	Antigen	Lot #	Manufac	Signature
Date Read	Results (mm)		Signature			

Follow-Up of significant tuberculin tests

Parent/Guardian notified of significant findings on _____ Date _____

Result of Diagnostic Studies: _____

Preventive Anti-Tuberculosis - Chemotherapy ordered.

_____ _____
No Date Yes Date