

**STATE COLLEGE AREA SCHOOL DISTRICT
STUDENT SERVICES
PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION**

NAME OF CHILD

LAST _____ **FIRST** _____ **MIDDLE** _____ **BIRTHDATE** _____ **GRADE** _____ **SEX** _____

IMMUNIZATION STATUS:

****GIVE DATE OF **LAST BOOSTER AND LAST TB TEST******

TRIPLE ANTIGEN(DPT) _____	MEASLES, MUMPS, RUBELLA _____
TETANUS-DIPHTHERIA(DT) _____	MEASLES, MUMPS, RUBELLA BOOSTER _____
TETANUS TOXIOD _____	MEASLES BOOSTER _____
Tdap _____	MUMPS BOOSTER _____
POLIO BOOSTER _____	MENINGOCOCCAL _____
VARICELLA VACCINE _____	VARICELLA BOOSTER _____
VARICELLA DISEASE _____	TUBERCULIN TEST DATE _____ RESULT _____
Month Year	
HEPATITIS B 1. _____ 2. _____ 3. _____	
OTHER: _____	
HEPATITIS A 1. _____ 2. _____	
HPV 1. _____ 2. _____ 3. _____	

MEDICAL HISTORY: (GIVE SIGNIFICANT DETAILS, INCLUDING SERIOUS ILLNESS ALLERGIES, OPERATIONS, ACCIDENTS)

REPORT OF EXAMINATION: (ELABORATE BELOW ON POSITIVE FINDINGS)

B/P _____	PULSE _____	HEIGHT _____	WEIGHT _____	VISION R 20/ _____	L 20/ _____	+LENS
				WEARS CORRECTIVE LENS YES <input type="checkbox"/> NO <input type="checkbox"/>		
	NORMAL ABNORMAL		NORMAL ABNORMAL		NORMAL ABNORMAL	
GENERAL NUTRITION	<input type="checkbox"/> <input type="checkbox"/>	GLANDS	<input type="checkbox"/> <input type="checkbox"/>	SKELETON	<input type="checkbox"/> <input type="checkbox"/>	
SKIN	<input type="checkbox"/> <input type="checkbox"/>	HEART	<input type="checkbox"/> <input type="checkbox"/>	POSTURE	<input type="checkbox"/> <input type="checkbox"/>	
EYES	<input type="checkbox"/> <input type="checkbox"/>	LUNGS	<input type="checkbox"/> <input type="checkbox"/>	EMOTIONAL STATUS	<input type="checkbox"/> <input type="checkbox"/>	
EARS	<input type="checkbox"/> <input type="checkbox"/>	ABDOMEN	<input type="checkbox"/> <input type="checkbox"/>	HEARING	<input type="checkbox"/> <input type="checkbox"/>	
NOSE AND THROAT	<input type="checkbox"/> <input type="checkbox"/>	GENITOURINARY	<input type="checkbox"/> <input type="checkbox"/>	SCOLIOSIS (BENDING POSITION)	<input type="checkbox"/> <input type="checkbox"/>	
TEETH AND GINGIVA	<input type="checkbox"/> <input type="checkbox"/>	NEURO MUSCULAR SYSTEM	<input type="checkbox"/> <input type="checkbox"/>			

IS THE CHILD UNDER TREATMENT? YES NO

SHOULD THIS CHILD HAVE RESTRICTIONS ON PLAY OR PHYSICAL EDUCATION ACTIVITIES? RECOMMENDATIONS:

WHAT OTHER RECOMMENDATIONS DO YOU WISH TO MAKE TO THE TEACHER OR SCHOOL NURSE WHICH MIGHT BE OF BENEFIT TO THIS CHILD FROM THE POINT OF VIEW OF EITHER PHYSICAL OR MENTAL HEALTH?

SIGNATURE OF EXAMINING PHYSICIAN	ADDRESS	
PHYSICIAN'S PRINTED NAME	TELEPHONE	DATE OF EXAMINATION