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

NAME OF CHILD

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

IMMUNIZATION STATUS: ****GIVE DATE OF **LAST BOOSTER** AND **LAST TB TEST******

TRIPLE ANTIGEN (DPT)_____ MEASLES, MUMPS, RUBELLA_____
TETANUS-DIPHTHERIA_____ MEASLES, MUMPS, RUBELLA BOOSTER_____
TETANUS TOXIOD_____ MEASLES BOOSTER_____
TdaP_____ MUMPS BOOSER_____
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)

VISION R 20/ L 20/ +LENS
B/P _____ PULSE_____ HEIGHT_____ WEIGHT_____ WEARS CORRECTIVE LENS YES ☐ NO ☐

	NORMAL	ABNORMAL		NORMAL	ABNORMAL		NORMAL	ABNORMAL
GENERAL NUTRITION	☐	☐	GLANDS	☐	☐	SKELETON	☐	☐
SKIN	☐	☐	HEART	☐	☐	POSTURE	☐	☐
EYES	☐	☐	LUNGS	☐	☐	EMOTIONAL STATUS	☐	☐
EARS	☐	☐	ABDOMEN	☐	☐	HEARING	☐	☐
NOSE AND THROAT	☐	☐	GENITOURINARY	☐	☐	SCOLIOSIS (BENDING POSITION)	☐	☐
TEETH AND GINGIVA	☐	☐	NEURO MUSCULAR SYSTEM	☐	☐			

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