**STATE COLLEGE AREA SCHOOL DISTRICT**

**STUDENT SERVICES**

**PRIVATE PHYSICIAN’S REPORT OF PHYSICAL EXAMINATION**

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**NAME OF CHILD**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **BIRTHDATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GRADE\_\_\_\_\_\_\_\_\_\_SEX\_\_\_\_\_\_\_\_\_**

**LAST** **FIRST** **MIDDLE**

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|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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**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 |  |  |
| SKIN |  | HEART |  |  |
| EYES |  | LUNGS |  |  |
| EARS |  | ABDOMEN |  |  |
| NOSE AND THROAT |  | GENITOURINARY |  |  |
| TEETH AND GINGIVA |  | NEURO MUSCULAR  | |  |
|  |  | SYSTEM |  |  |
| IS THE CHILD UNDER TREATMENT? | | YES  NO  |  |  |

SKELETON

POSTURE

EMOTIONAL STATUS

HEARING

SCOLIOSIS (BENDING POSITION)

* 
* 
* 
* 
* 

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 |
|  |  |  |

HS- 32 5/14