

PARKLAND SCHOOL DISTRICT
Allentown, PA 18104
PRIVATE PHYSICIAN'S REPORT OF
PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL _____ DATE _____

NAME OF CHILD _____ AGE _____ SEX _____ M _____ F _____
Last First Middle

ADDRESS:

No. and Street _____ City/Post Office _____ Borough or Township _____ County _____ State _____ Zip _____

MEDICAL HISTORY
Immunizations and Tests

<u>Immunization Status:</u>	<u>*List All Dates</u>
*Copy of vaccines enclosed with physical, check one: ___ (yes) ___ (no)	
<u>Diphtheria and Tetanus</u>	_____
<u>Tdap Booster</u>	_____
<u>Tetanus Booster(Td)</u>	_____
<u>Polio</u>	_____
<u>Measles (Hard, Red)(list both doses)</u>	_____
<u>Rubella (German Measles)</u>	_____
<u>Mumps</u>	_____
<u>Hepatitis B (list all 3 doses)</u>	_____
<u>Varivax</u>	_____ <u>Booster</u>
<u>Varicella Disease</u>	<u>Date:</u> _____
<u>Menactra(MCV)</u>	_____
<u>Other</u>	_____
<u>Date of last tuberculin test:</u>	_____
<u>Type:</u>	<u>Result:</u> _____

Significant Medical History: (Including serious illness, accidents, surgery)

Is the child under treatment? ___ Yes ___ No

If yes, explain: _____

Is the child taking medication? ___ Yes ___ No

If yes, explain: _____

Should this child have restrictions on play or physical education activity? _____

If yes, recommendation: _____

What other recommendations do you wish to make: _____

Continued on Back

NAME OF CHILD _____ GRADE _____

Last

First

Middle

Significant Medical Conditions (4)

	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"/>	_____

Report of Physical Examination (4)

	Normal	Abnormal	If Abnormal, Explain
* Height (inches)			
* Weight (pounds)			
* Pulse ()			
* Blood Pressure /			
* Hair/Scalp			
* Skin			
* Eyes -- Visual Acuity R__/_L__/_			
* Eyes -- Color Vision			
* Ears -- Hearing dB R L			
* Nose and Throat			
* Teeth and Gingiva			
* Lymph Glands			
* Heart -- Murmur, etc.			
* Lung -- Adventitious Findings			
* Abdomen			
* Genitalia			
* Scoliosis -- Bending Position			
* Neuromuscular System			
* Extremities			

_____ Date of Examination

_____ Signature of Examiner

_____ Print Name of Examiner

_____ Address

_____ Telephone