H511.336 (Rev 5/02)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

DATE _____ 20_____

NAME OF SCHOOL _____ GRADE _____ HOMEROOM _____

NAME OF CHILD	DATE OF BIRTH	SEX
Last First Middle		☐ M ☐ F

ADDRESS

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

MEDICAL HISTORY
IMMUNIZATIONS AND TESTS

VACCINE	Enter Month, Day, and Year each immunization was given DOSES			BOOSTERS & DATES	
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, TD	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (Circle): OPV, IPV	1 / /	2 / /	3 / /	4 / /	5 / /
Measles, Mumps, Rubella	1 / /	2 / /			
Hepatitis B	1 / /	2 / /	3 / /		
HIB	1 / /	2 / /	3 / /		
Varicella	1 / /	2 / /	Varicella Disease or Lab Evidence Date: _____		
Other: _____					

☐ 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)

If Applicable:

Tuberculin Tests Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	**Results (mm)**		**Signature**		

Follow-Up of significant tuberculin tests:
Parent/Guardian notified of significant findings on _____.

Result of Diagnostic Studies: _____.
Preventive Anti-Tuberculosis – Chemotherapy ordered. ☐ No ☐ Yes _____ Date

Significant Medical Conditions (√)
If Yes, Explain

	Yes	No	
Allergies	☐	☐	
Asthma	☐	☐	
Cardiac	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder	☐	☐	
Hypertension	☐	☐	
Neuromuscular Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder	☐	☐	
Other (Specify)	☐	☐	

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education? If so, specify _____

Report of Physical Examination (√)

	Normal	Abnormal	Not Examined	Comments
▪ Height (inches)				
▪ Weight (pounds) BMI				
▪ Pulse ( )				
▪ Blood Pressure				
▪ Hair/Scalp				
▪ Skin				
▪ Eyes/Vision				
▪ Ears/Hearing				
▪ Nose and Throat				
▪ Teeth and Gingiva				
▪ Lymph Glands				
▪ Heart – Murmur, etc				
▪ Lung – Adventitious Finding				
▪ Abdomen				
▪ Genitourinary				
▪ Neuromuscular System				
▪ Extremities				
▪ Spine (Presence of Scoliosis)				

_____
Date of Examination

_____
Signature of Examiner

_____
PRINT Name of Examiner

_____
Address

_____
Telephone Number

H514.025 (Rev. 3/99)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

SCHOOL DENTAL HEALTH RECORD

SCHOOL DISTRICT	COUNTY	DATE OF BIRTH
NAME OF STUDENT LAST FIRST MIDDLE	GRADE	SEX M ☐ F ☐
HOME ADDRESS		TELEPHONE NO.

THE ABOVE INFORMATION SHOULD BE FILLED IN BEFORE THE EXAMINATION OR EVALUATION

Record on Dental Chart **d** (decayed), **e** (indicated for extraction), and **f** (filled) for deciduous teeth and **D** (Decayed), **M** (Missing), and **F** (Filled) for permanent teeth

TOOTH CHART

		RIGHT								LEFT								
UPPER		1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	UPPER
LOWER		32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	LOWER
First Exam	Upper																	Upper
	Lower																	Lower
Second Exam	Upper																	Upper
	Lower																	Lower
Third Exam	Upper																	Upper
	Lower																	Lower
Fourth Exam	Upper																	Upper
	Lower																	Lower
Fifth Exam	Upper																	Upper
	Lower																	Lower

STUDENT REFERRAL

DATE	EXAMINED OR EVALUATED BY	REFERRED TO	REMARKS

NAME OF STUDENT _____

DENTAL FINDINGS – Check Applicable Items

Grade	Date	EXAMINED OR EVALUATED BY	Prophylasix	SPECIAL PROJECTS (Specify)	FLUORIDE		Oral Evaluation Passed/ Referred	TOTALS		Tooth Brush Instructions	Nutrition Counseling
					Tablet	Mouth Rinse		Def DMF	OHI Index		
K											
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
Other											

REMARKS:

DATE	
DATE	
DATE	
DATE	
DATE	
DATE	