Dear Parent(s)/Guardian(s):

The Pennsylvania School Health Act requires a medical examination of every student entering school for the first time, sixth grade and eleventh grade. **Please be aware that the examination for female genitalia <u>will not</u> be conducted as part of the school exam. The examination of genitalia for males, however, <u>will occur</u>.**

The Law gives you a choice of having the examination done by the school physician or by your family physician at your own expense. Because your family physician has a better knowledge of your child's past physical history than the school physician and is in the best position to recommend necessary remedial treatment and give necessary immunizations, we urge you to consider having the examination done by your family physician.

Please complete the lower portion of the form at this time and return to the school nurse.

If you choose to take your child to your family physician, the attached Private Physician's Report must be returned to school by **<u>October 31st</u>** of the current school year. The private physical examination must have been completed no earlier than the previous **January 1st**.

If the physical examination, as required through the Department of Health, is not completed and proof submitted to the appropriate school nurse, your child may be excluded from school.

If you choose to have the examination done by the school physician during the school year, you will be advised of any condition requiring the attention of your family physician.

Sincerely,

Michael W. Michaels
Superintendent

****

(Return to School Nurse)

CHILD'S NAME _____

SCHOOL: _____ GRADE: _____

_____ I CHOOSE TO HAVE MY CHILD'S PHYSICAL EXAMINATION DONE BY MY FAMILY PHYSICIAN. Please sign below and return slip to school.

Date of exam by Family Physician: _____

_____ I CHOOSE TO HAVE MY CHILD'S PHYSICAL EXAMINATION DONE BY THE SCHOOL PHYSICIAN AND GIVE MY PERMISSION BY SIGNING BELOW. Please sign below and return slip to school nurse.

_____

Parent/Guardian Signature Date

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 | Zp 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. _____
Date

Result of Diagnostic Studies: _____ .
Date

Preventive Anti-Tuberculosis - Chemotherapy ordered. ☐ No ☐ Yes _____ Date

Significant Medical Conditions (✓)

	Yes	No	If Yes, Explain
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 Findings				
• Abdomen				
• Genitourinary				
• Neuromuscular System				
• Extremities				
• Spine (Presence of Scoliosis)				

_____
Date of Examination

_____
Signature of Examiner

_____
Print Name of Examiner

_____
Address

_____
Telephone Number