

**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		<input type="checkbox"/> M <input type="checkbox"/> F

ADDRESS

No. and Street	City or Post Office	Borough or Township	County	State	Zip Code
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**MEDICAL HISTORY  
IMMUNIZATIONS AND TESTS**

VACCINE	Enter Month, Day, and Year each immunization was given			BOOSTERS & DATES	
	DOSES				
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: <u>Menactra (MCV)</u>	1 / /	2 / /			

- 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 \_\_\_\_\_