WILLIAMSBURG COMMUNITY SCHOOL DISTRICT
Student Health Services
PHYSICAL EXAMINATION

Dear Parent or Guardian:

Pennsylvania School Law requires all school age children to have periodic physical examinations as follows: Kindergarten or grade 1, grade 6, and grade 11. Transfer students, as well as students with incomplete health records, shall be required to have a physical examination as the need arises.

Since your child has probably been under the care of a family physician, we feel that he or she can best evaluate your child's health, provide a more extensive examination, and assist you in obtaining any necessary treatment or correction. The family physician's examination of your child should be done, preferably during the summer.

Please return the completed Private Physician's Report form to the school nurse at the beginning of the school year. If it has not been completed prior to that time, please indicate the date of your child's appointment and return the completed form after the exam, or indicate that you wish to have your child examined by the school physician.

Completed private examination forms must be returned prior to the date the school examinations are scheduled or your child will be scheduled for a medical examination at the school by the school physician. You will be notified in advance as to the date school examinations will be held. If you have any questions regarding this health program requirement, please contact the school nurse.

Respectfully,

Christine Ebersole, RN, BSN, CSN

PLEASE FILL OUT THIS PORTION AND RETURN TO THE SCHOOL NURSE IF YOUR CHILD HAS NOT BEEN EXAMINED BY YOUR PHYSICIAN PRIOR TO THE FIRST DAY OF SCHOOL

To the school nurse:

Child's Name:_____ Grade:_____

_____ I wish to have my family physician examine my child. Provide the date of appointment and name of the physician if this has not been completed.

Date of appointment:_____

Name of Physician:_____

(Please return the private Physician's Report Form as soon as the examination has been completed.)

_____ I wish to have the examination done by the school physician at school.

Please list any health concerns that you wish to bring to the attention of the examining physician:

_____

_____

_____

_____

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 | 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. _____ Date

Results of Diagnostic Studies: _____ Date

Preventive Anti-Tuberculosis – Chemotherapy ordered. ☐ NO ☐ YES _____ Date

(Continued on Back)

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 effect 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 & 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