pennsylvania DEPARTMENT OF HEALTH

Bureau of Community Health Systems Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:

Complete page one of this form <u>before</u> student's exam. Take completed form to appointment.

Date of birth

Age at time of exam_

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

Does the student have any allergies?
No
Yes (If yes, list specific allergy and reaction.)

□ Medicines

□ Food

□ Stinging Insects

V=0 N0

Gender:
Male
Female

Today's date_

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

1. Aryongoing medical conditions? If itso, please identify:	GENERAL REALTR: Ras the student	TES		GENITOURINART: Has the student	TES	NO	
Other Issue relayed more than one night in the hospital? Issue relayed more than one night in the hospital? Issue relayed more than one night in the hospital? Issue relayed more than one night in the hospital? Issue relayed more than one night in the hospital? Issue relayed more than one night in the hospital? Issue relay with a weak of the second more than one night in the hospital? Issue relay with a weak of the second more than one night in the hospital? Issue relay with a weak of the second more than one night in the hospital? Issue relay with a weak of the second more than one night in the hospital? Issue relay with a weak of the second more than one th	, , , , , , , , , , , , , , , , , , , ,			29. Had groin pain or a painful bulge or hernia in the groin area?			
2. Ever stayed more than one night in the hospital? If Self MALES ONL? If deal mestivula period? If Self MALES ONL? Head mestivula period? 3. Ever had surgery? How many periods has she had in the last 12 months? No 4. Ever had server? How many periods has she had in the last 12 months? No 5. Head history of being born without or is missing a kidney, an eye, at leastick (males), spleen, or any other organ? YES No 6. Ever become ill while exercising in the heat? 33. Name of student's dents: Ital set had any pain or problems with hisher gums or teeth? 8. Had headaches with exercise? OI Self and hung or concussion? VES NO 9. Ever had a head injury or concussion? YES NO 36. Been told heide has a learing disability, tolghting behavior. YES NO 18. Ever had a hind or blow to the head that caused confusion, prolonged head hit or blow to the head that a bit or blow to head hit or blow to head hits or blow so more legs different bills? 35. Been told heide has a curved spine or scolies? NO 19. Ever had a hinder or falsan as the student				30. Had a history of urinary tract infections or bedwetting?			
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B Noticed or been told he/she has a curved spine or scoliosis? 38. Been worried, sad, upset, or angry much of the time? 39. Shown a general loss of energy, motivation, interest or enthusiasm? 44. Had any problem with his/her eyes (vision) or had a history of an eye injury? 39. Shown a general loss of energy, motivation, interest or enthusiasm? 40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight or received a recommendation to gain or lose weight? 41. Used (or currently uses) tobacco, alcohol, or drugs? 41. Used (or currently uses) tobacco, alcohol, or drugs? 41. Used (or currently uses) tobacco, alcohol, or drugs? 41. Used (or currently uses) tobacco, alcohol, or drugs? 41. Used (or currently uses) tobacco, alcohol, or drugs? 42. Is there a family history of the following? If so, check all that apply: 41. Used (or currently uses) tobacco, alcohol, or drugs? 42. Is there a family history of the following? If so, check all that apply: 42. Is there a family history of any of the following? If so, check all that apply: 43. Is there a family history of any of the following heart-related problems 56. Other 43. Had alcomfort, pain, tightness or chest pressure during exercise? 43. Is there a family history of any of the following heart-related problems? If so, check all that apply: 43. Is there a family history of any of the following heart-related problems? If so, check all that apply: 44. Has any family member had unexplained fainting, une							
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Heap prescribed glasses or contact lenses? HEART/LUNGS: HART/LUNGS: Hart apply: Cever had the doctor say he/she has a heart problem? If so, check all that apply: High blood pressure High blood pressure High cholesterol Other	eye injury?						
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28. Ever had herpes or a MRSA skin infection? yes, write them on page 4 of this form.)	following an injury? 26. Had joints that become painful, swollen, feel warm, or look red? SKIN: Has the student	YES	NO				

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student

Adapted in part from the *Pre-participation Physical Evaluation History Form*; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes D No D						
		CHECK ONE				
Physical exam for grade: K/1 □ 6 □ 11 □ □	Other	NORMAL	*ABNORMAL	DEFER	*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS	
Height: () in	nches					
Weight: () po	ounds					
BMI: ()						
BMI-for-Age Percentile: () %					
Pulse: ()						
Blood Pressure: (/)					
Hair/Scalp						
Skin						
Eyes/Vision Correcte	ed 🗆					
Ears/Hearing						
Nose and Throat						
Teeth and Gingiva						
Lymph Glands						
Heart						
Lungs						
Abdomen						
Genitourinary						
Neuromuscular System						
Extremities						
Spine (Scoliosis)						
Other						
TUBERCULIN TEST DATE APPLIED DATE READ		٩D	RESULT/FOLLOW-UP			
MEDICAL CONDI	TIONS OR	CHRON	VIC DIS	EASE	S WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION	
(Additional space on page 4)						

Parent/guardian present during exam: Yes \Box No \Box						
Physical exam performed at: Personal Health Care Provider's Office exam20	Date	Date of				
Print name of examiner						
Print examiner's office address	Ph	Phone				
Signature of examiner		MD 🗆	DO 🗆			

HEALTH CARE PROVIDERS: Please photocopy immunization history from student's record – OR – insert information below.

IMMUNIZATION EXEMPTION(S):							
Medical 🗌	Date Issued:	Reason:	Date Rescinded:				
Medical 🗌	Date Issued:	Reason:	Date Rescinded:				
Medical 🗌	Date Issued:	Reason:	Date Rescinded:				
NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.							

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization							
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5			
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5			
Polio Type: OPV or IPV	1	2	3	4	5			
Hepatitis B (HepB)	1	2	3	4	5			
Measles/Mumps/Rubella (MMR)	1	2	3	4	5			
Mumps disease diagnosed by physician	Date:							
Varicella: Vaccine 🗌 Disease 🗌	1	2	3	4	5			
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5			
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5			
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5			
	1	2	3	4	5			
Influenza Type: TIV (injected) LAIV (nasal)	6	7	8	9	10			
	11	12	13	14	15			
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5			
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5			
Hepatitis A (HepA)	1	2	3	4	5			
Rotavirus	1	2	3	4	5			
Other Vaccines: (Type and Date)								