Cumberland Valley School District

Private Physician's Report Of Physical Examinations Of A Pupil of School Age

Dear Parent/Guardian:

Pennsylvania School Health Law requires all children to have a medical examination **upon original entry into school**, in **sixth grade** and in **eleventh grade**. These examinations are recommended because these are critical periods in the growth and development of your child. We are recommending that this examination be done by *your family physician*, since he/she can best evaluate your child's health, assist you in obtaining necessary treatment, and keep your child's immunization status current.

We are giving you this form early in order that *your physician* may have time to examine, treat and immunize your child. If this examination is not done privately by your family physician, it will be given at school by a school physician.

Please have your physician complete this form and return it signed to **your child's school,** marked to the attention of the School Nurse by **August 15.**

Your cooperation in this matter is greatly appreciated.

Name of child	Age	❑ Male ❑ Female	Birth Date
Address			

Immunization Status	Doses required by state law before child enters school are shaded.			Tetanus Immunization – dose recommended @ 11/12 years	
Diphtheria – Tetanus (DtaP, DTP, Td or DT) **	/ /	/ /	/ /	/ /	/ /
Tdap ****	/ /	/ /	/ /	/ /	
Polio (OPV or IPV)	/ /	/ /	/ /	/ /	
Menactra(MCV) ****	/ /	/ /	/ /	/ /	
Hepatitis B	/ /	/ /	/ /		
Measles–Mumps–Rubella(MMR)*	/ /	/ /	Measles Serology	Date	Titer
Varicella -* Required ***	/ /	/ /	Rubella Serology:	Date	Titer
Other	/ /	/ /	Mumps disease diagnosed by a physician:	Date	

* Immunization must be given after 12 months of age
** A 4th dose of tetanus and diphtheria (Td) including one dose on or after the fourth birthday
*** Immunization or documented history of disease
**** Required Grade 7

Most recent T.B. Test: Type _____ Date _____ Results _____

Any restrictions on play or physical activities? _____

Any current medication? Name _____

Dosage _____ Frequency_____

(Continued on back)

Significant Medical Conditions (X)

	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			
Speech Disorder			
Vision Disorder			
Other (Specify)			

Report of Physical Examination (x)	Normal	Abnormal	If Abnormal, Explain
Height (inches)			
Weight (pounds)			
Pulse ( )			
Blood Pressure /			
Hair/Scalp			
Skin			
Eyes-Visual Acuity R / L			
Ears-Hearing dB R / L			
Nose and Throat			
Teeth and Gingiva			
Lymph Glands			
Heart Murmur, etc.			
Lung			
Abdomen			
Genitalia			
Neuromuscular System			
Extremities			
Spine (Presence of Scoliosis)			

Date of Examination _____ Print Name of Examiner _____

Signature of Examiner _____ Address _____