

DELAWARE VALLEY SCHOOL DISTRICT
PRIVATE PHYSICIAN'S REPORT OF
PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE

Name of School _____ Grade _____ Homeroom _____

Name of Child _____ Date of Birth _____ Sex: M F

PLEASE ATTACH CURRENT IMMUNIZATION RECORD FROM DOCTOR OR CLINIC

Medical History (if yes, explain)

Allergies ----- Y N _____ Hypertension-----Y N _____
 Asthma----- Y N _____ Neuromuscular Disorder -----Y N _____
 Cardiac----- Y N _____ Orthopedic Condition----- Y N _____
 Drug/Alcohol Dependency---- Y N _____ Respiratory Illness-----Y N _____
 Diabetes-----Y N _____ Seizure Disorder----- Y N _____
 Gastrointestinal Disorder-----Y N _____ Skin Disorder-----Y N _____
 Hearing Disorder-----Y N _____ Vision Disorder-----Y N _____
 Other (specify) -----Y N _____

Please list any special medical problems or medications the student takes.

PHYSICAL EXAM

Height _____ Weight _____ BMI _____ Pulse _____ Blood Pressure _____

System	Normal	Abnormal	Deferred	Comment
Hair/Scalp				
Skin				
Eyes/Vision				
Ears/Hearing				
Nose & Throat				
Teeth & Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular/Extremities				
Spine/Scoliosis				

Is the child under treatment ? _____ Yes _____ No

Does the child have any restrictions on play or physical education activities? _____ Yes _____ No

Date of Exam _____

Signature of Examiner _____

Phone _____

PRINT name _____