

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/Screening Result		
Hair/Scalp						
Skin						
Eyes & Vision Screening				OD	OS	REFER
Ears & Hearing Screening				PASS	FAIL	REFER
Nose & Throat						
Teeth & Gingiva						
Lymph Glands						
Heart						
Lungs						
Abdomen						
Genitourinary						
Neuromuscular/Extremities						
Spine/Scoliosis						
Psycho-Social Screening				WNL	REFER: Y N	

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 _____