

**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			BOOSTERS & DATES	
	DOSES				
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





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Date of Examination

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Signature of Examiner **PRINT** Name of Examiner

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Address Telephone Number