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 before student's exam. Take completed form to appointment.

Student's name _____ Today's date_____

Date of birth _____ Age at time of exam_____ Gender: ☐ Male ☐ Female

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 ☐ Pollens ☐ Food ☐ Stinging Insects

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

GENERAL HEALTH: ***Has the student…***	**YES**	**NO**
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other_____	☐	☐
2. Ever stayed more than one night in the hospital?	☐	☐
3. Ever had surgery?	☐	☐
4. Ever had a seizure?	☐	☐
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?	☐	☐
6. Ever become ill while exercising in the heat?	☐	☐
7. Had frequent muscle cramps when exercising?	☐	☐
HEAD/NECK/SPINE: ***Has the student…***	**YES**	**NO**
8. Had headaches with exercise?	☐	☐
9. Ever had a head injury or concussion?	☐	☐
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?	☐	☐
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?	☐	☐
12. Ever been unable to move arms or legs after being hit or falling?	☐	☐
13. Noticed or been told he/she has a curved spine or scoliosis?	☐	☐
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?	☐	☐
15. Been prescribed glasses or contact lenses?	☐	☐
HEART/LUNGS: ***Has the student...***	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?	☐	☐
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:_____	☐	☐
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?	☐	☐
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded **DURING** or **AFTER** exercise?	☐	☐
20. Had discomfort, pain, tightness or chest pressure during exercise?	☐	☐
21. Felt his/her heart race or skip beats during exercise?	☐	☐
BONE/JOINT: ***Has the student...***	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?	☐	☐
23. Had an injury to a muscle, ligament, or tendon?	☐	☐
24. Had an injury that required a brace, cast, crutches, or orthotics?	☐	☐
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?	☐	☐
26. Had joints that become painful, swollen, feel warm, or look red?	☐	☐
SKIN: ***Has the student…***	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?	☐	☐
28. Ever had herpes or a MRSA skin infection?	☐	☐

GENITOURINARY: ***Has the student…***	**YES**	**NO**
29. Had groin pain or a painful bulge or hernia in the groin area?	☐	☐
30. Had a history of urinary tract infections or bedwetting?	☐	☐
31. **FEMALES ONLY:** Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?	☐	☐
33. Name of student's dentist: _____ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: ***Has the student…***	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?	☐	☐
35. Been bullied or experienced bullying behavior?	☐	☐
36. Experienced major grief, trauma, or other significant life event?	☐	☐
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?	☐	☐
38. Been worried, sad, upset, or angry much of the time?	☐	☐
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?	☐	☐
41. Used (or currently uses) tobacco, alcohol, or drugs?	☐	☐
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Asthma/lung problems ☐ Behavioral health issue ☐ Diabetes ☐ Inherited disease/syndrome ☐ Kidney problems ☐ Seizure disorder ☐ Sickle cell trait or disease Other_____	☐	☐
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ Cardiomyopathy ☐ High blood pressure ☐ High cholesterol ☐ QT syndrome ☐ Marfan syndrome ☐ Ventricular tachycardia ☐ Other_____	☐	☐
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?	☐	☐
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?	☐	☐
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)	☐	☐

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_____ Date_____

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 ☐ No ☐

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	CHECK ONE: NORMAL	CHECK ONE: *ABNORMAL	CHECK ONE: DEFER	*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
Height: ( ) inches	☐	☐	☐	
Weight: ( ) pounds	☐	☐	☐	
BMI: ( )	☐	☐	☐	
BMI-for-Age Percentile: ( ) %	☐	☐	☐	
Pulse: ( )	☐	☐	☐	
Blood Pressure: (/)	☐	☐	☐	
Hair/Scalp	☐	☐	☐	
Skin	☐	☐	☐	
Eyes/Vision Corrected ☐	☐	☐	☐	
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	RESULT/FOLLOW-UP

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam_____20_____

Print name of examiner _____

Print examiner's office address_____ **Phone**_____

Signature of examiner_____ **MD ☐ DO ☐ PAC ☐ CRNP ☐**

STUDENT NAME:

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
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	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)					

 ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)
STUDENT NAME: