Please keep a copy for your records **DUE SEPTEMBER 15th**

Springfield School District
Springfield, PA 19064

PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION OF SCHOOL AGE CHILD

(Required of K, 6th and 11th grade students and new entrants)

Name LAST ____ First ____ Middle ____ Age ____ Sex ____ Height ____ Weight ____

Address ____ Phone ____

Immunization Status

Vaccine	Number of Doses Required by Law	Dates Received (day, month and year)				
Tetanus-Diphtheria	4					
Pertussis	-					
Polio	3					
Measles	2					
Rubella	2					
Mumps	2					
Hepatitis B	3					
Varicella	-					
Meningitis	-					
Tuberculin Tests	Date-Last					

Medical History

Give significant details of child's medical history, including serious illness, operations, accidents, etc.

____

____

Reports of Examination

Do you find evidence of any of the following: (if yes, elaborate on reverse side)

Visual Acuity O.D.___ O.S.___
Eye strain or eye disease Yes ___ No ___
Nutritional disease Yes ___ No ___
Psychological concerns Yes ___ No ___
Nose or throat abnormality Yes ___ No ___
Heart abnormality Yes ___ No ___
Asthma Yes ___ No ___
Abdominal abnormality Yes ___ No ___

Hearing test results Right ear___Left ear___
Dental or gingival disease Yes ___ No___
Allergy Yes ___ No___
Orthopedic abnormality Yes ___ No___
Other conditions specify: ____

____

____

Blood pressure ____

Is this child under treatment? Yes___No___

Should this child have restrictions on play or physical education activites? Yes___ No___

Recommendations: ____

____

Scoliosis Screening: Results ____

Date ____ Physician ____ Address ____

Form H-7 revised 07/10