(Student Health Service File)

North Allegheny School District

Private Physician's Report of Physical Examination of School-Aged Student

PARENT/GUARDIAN SECTION (LINES 1, 2, 3, and 4):

1. **Student's Full Name:** ____ **Date of Birth:** _________________

2. **School:** _______________________________ / *To be completed by NASD:* ***Grade:*** ______ ***Section:*** _______ ***ID#*** _______________

3. **Father's Full Name**: __________________________________ **Mother's Full Name:** ______________________________________

4. **Preferred Phone # (Home):** _______________________ **(Cell):** _______________________ **(Work):** _______________________

PHYSICIAN SECTION (LINES 5, 6, 7, 8, and 9):

5. **IMMUNIZATION**: PROVIDE DATES OF ANY BOOSTERS GIVEN AFTER BASIC SERIES OR ON DAY OF EXAM IF NOT INCLUDED IN FILE

DTAP Date ______________; *MMR #1Date* ________________#2 Date _______________ *Chicken Pox - Date of Disease* ____________________

Varicella Vaccine #1Date _______________ *#2Date* _______________ ; **Lead** *#1 Date*_____________________ *#2 Date*_______________

Other _________________________________ *Date* ___________;

Other _________________________________*Date*___________ ;

**Grades 7 – 12 -- in addition:*
7th grade students must have completion of Tdap and 1st dose of MCV
12th grade students must have Tdap and completion of 2nd dose of MCV

6. **MEDICAL HISTORY:**

Allergies *(please specify):* ____

Hospitalizations/Surgery/Accidents/Serious Illness: *(please specify)*

(DATE) ____ *(DATE)* ____

*(DATE)*____ *(DATE)* ____

7. **REPORT OF EXAMINATION**: *** Please elaborate below on "abnormal" findings.**

	NORMAL	ABNORMAL		NORMAL	ABNORMAL		NORMAL	ABNORMAL
General Nutrition			Glands			Skeleton		
Skin			Heart			Scoliosis- Bending Position		
Eyes			Lungs			Emotional Status		
Ears			Abdomen			***Height*** _________ ***Weight*** ________		
Nose & Throat			Genitalia			***BP*** __________ ***Pulse*** __________		
Teeth & Gingiva			Neuro Muscular System			Wears Corrective Lens: Yes ____ No _____		

***Abnormal findings**: ____

8. **RESTRICTIONS**: Should this child have restrictions on play or physical education activities? **NO** _____ **YES** _____ ***If "YES", please explain:***

____

9. **RECOMMENDATIONS**: What recommendations do you wish to make to the teacher or School Nurse, which might be of benefit to this child?

____

DATE OF EXAMINATION: ___________________ **PHYSICIAN'S NAME:** ____

(Please print Physician's name)

SIGNATURE OF PHYSICIAN, CRNP, or PA: ____

(Signature of Physician, CRNP, or PA)

PHYSICIAN'S ADDRESS: ____ **PHONE #**________________________

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