CENTRAL COLUMBIA SCHOOL DISTRICT

4777 OLD BERWICK ROAD
BLOOMSBURG, PENNSYLVANIA 17815-3515

District Administration Office

High School & Athletic Office

Middle School Office

Elementary School Office

Dear Parent/ Guardian:

Pennsylvania School Health Law states that children attending school must have a complete physical examination upon original entry (kindergarten or first grade), sixth and eleventh grade.

Your child is scheduled for a physical examination this year. You have two options for completing this state requirement.

- This examination may be done by your family physician at your expense by using the attached **Private Physician Report Form.** The completed form must be **returned to the school nurse by September 1st.** It is felt that an examination by your family physician is more meaningful because of their familiarity with the student's health history.

- The school physician will complete the examination at the school's expense. The students will be notified in advance of the examination date.

Please indicate your choice and return this form to the school nurse.

I grant permission for the school physician to complete a physical examination on my child.

I will have my child examined by a private physician and return the completed form to the school nurse by September 1st. If the completed Private *Physician Report Form* is not returned by September 1st, the student will be scheduled for a school physical.

Student Name:

Parent/Guardian Signature: **Date:**

Thank you for your cooperation.

Trudy Faux, RN, CSN, MSN
Elementary School

Jean Flick, RN
Middle School

Jan Dubbs, RN, BSN,CSN
High School

Jocelyn Elders

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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 DOSES			BOOSTERS & DATES	
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
Date Read	**Results (mm)**		**Signature**		

Follow-Up of significant tuberculin tests:

Parent/Guardian notified of significant findings on. Date

Result of Diagnostic Studies: Date

Preventive Anti-Tuberculosis - Chemotherapy ordered. No Yes Date

(Continued on Back)

Significant Medical Conditions (✓)

	Yes	No	If Yes, Explain
Allergies	☐	☐	
Asthma	☐	☐	
Cardiac	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder	☐	☐	
Hypertension	☐	☐	
Neuromuscular Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder	☐	☐	
Other (Specify)	☐	☐	

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education? If so, specify _____

Report of Physical Examination (✓)

	Normal	Abnormal	Not Examined	Comments
• Height (inches)				
• Weight (pounds) BMI				
• Pulse ( )				
• Blood Pressure /				
• Hair/Scalp				
• Skin				
• Eyes/Vision				
• Ears/Hearing				
• Nose and Throat				
• Teeth and Gingiva				
• Lymph Glands				
• Heart — Murmur, etc.				
• Lung — Adventitious Findings				
• Abdomen				
• Genitourinary				
• Neuromuscular System				
• Extremities				
• Spine (Presence of Scoliosis)				

_____
Date of Examination

_____
Signature of Examiner

_____
Print Name of Examiner

_____
Address

_____
Telephone Number