



UPPER DARBY SCHOOL DISTRICT

Private Physical Examination

209-AR-2
10-01-2016

Report of Physical Examination: k/1 ___ 6 ___ 11 ___ other ___ Date: _____

Name _____ Birthdate _____ Grade _____ Sex _____
Last First

Home Address _____ Home Phone _____
Street City Zip

Vaccine	Please give exact dates											
Dtap DPT Td	1		2		3		4		5			
Tdap (Adacel)	1		2									
Polio(OPV,IPV)	1		2		3		4					
Hepatitis B	1		2		3		4					
MMR	1		2									
Varivax	1		2							Varicella Disease Date: _____		
MCV (meningococcal)									Other: _____			
PPD					Result: _____		INH Therapy: _____		Other: _____			

_____ MEDICAL EXEMPTION (Please also complete and return 203-AR-3)

_____ RELIGIOUS EXEMPTION (Please also complete and return 203-AR-4)

Allergy _____ Epi-pen ___ Yes ___ No

Medical History _____

Surgical History _____

Height ___ (inches) Weight ___ (lbs.) BMI-for-Age Percentile ___ % BP ___/___ Pulse ___

	Normal	Abnormal		Normal	Abnormal
General Nutrition _____	<input type="checkbox"/>	<input type="checkbox"/>	Skin _____	<input type="checkbox"/>	<input type="checkbox"/>
Neuro Muscular _____	<input type="checkbox"/>	<input type="checkbox"/>	Ears _____	<input type="checkbox"/>	<input type="checkbox"/>
Extremities _____	<input type="checkbox"/>	<input type="checkbox"/>	Nose & Throat _____	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary _____	<input type="checkbox"/>	<input type="checkbox"/>	Glands _____	<input type="checkbox"/>	<input type="checkbox"/>
Hearing _____	<input type="checkbox"/>	<input type="checkbox"/>	Heart _____	<input type="checkbox"/>	<input type="checkbox"/>
Spine (scoliosis) _____	<input type="checkbox"/>	<input type="checkbox"/>	Lungs _____	<input type="checkbox"/>	<input type="checkbox"/>
Speech _____	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen _____	<input type="checkbox"/>	<input type="checkbox"/>
Teeth and Gingiva _____	<input type="checkbox"/>	<input type="checkbox"/>	Vision R: 20/___ L: 20/___		
			Wears Corrective Lens Yes ___ No ___		

Is this student currently under treatment? No ___ Yes _____

Please list any current or long-term medications (reason for administration): _____

Should this student have any physical restrictions? _____

Signature of Examining Physician _____ Phone _____

Printed name _____ Office Stamp: _____