

**PENN-HARRIS-MADISON SCHOOL HEALTH SERVICES  
PHYSICAL EXAMINATION**

Name \_\_\_\_\_ Grade \_\_\_\_\_

School \_\_\_\_\_ Date of Birth \_\_\_\_\_

**PHYSICIAN'S EXAMINATION**

Height \_\_\_\_\_ Weight \_\_\_\_\_

Eyes \_\_\_\_\_

Glasses \_\_\_\_\_

Ears \_\_\_\_\_

Nose \_\_\_\_\_

Throat \_\_\_\_\_

Chest \_\_\_\_\_

Heart \_\_\_\_\_

Blood Pressure \_\_\_\_\_

Scoliosis \_\_\_\_\_

Hernia \_\_\_\_\_

Feet \_\_\_\_\_

Urinalysis \_\_\_\_\_ Neg. \_\_\_\_

Sugar \_\_\_\_\_ Albumin \_\_\_\_\_

Physically fit to participate in P.E.?  
Yes                      No

Physically fit for competitive sports? Yes

**Immunization Record (month, day, year)**

**HEPATITIS B:** 1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_

**HEPATITIS A:** 1. \_\_\_\_\_ 2. \_\_\_\_\_

**VARICELLA:** 1. \_\_\_\_\_ 2. \_\_\_\_\_  
**CHICKEN POX DISEASE** \_\_\_\_\_ (month & yr)

**DPT, DTaP, DT, TD, TdaP:**

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

5. \_\_\_\_\_ 6. \_\_\_\_\_

**POLIO (IPV/OPV):**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

4. \_\_\_\_\_

**MMR:**

1. \_\_\_\_\_ 2. \_\_\_\_\_

T.B. Test Date \_\_\_\_\_ Type \_\_\_\_\_

Neg. \_\_\_\_\_ Pos. \_\_\_\_\_

Size of Induration \_\_\_\_\_ mm

X-ray \_\_\_\_\_ Date \_\_\_\_\_

Sickle Cell Testing Date \_\_\_\_\_

Neg. \_\_\_\_\_ Pos. \_\_\_\_\_

Lead Poisoning Testing Date \_\_\_\_\_

Neg. \_\_\_\_\_ Pos. \_\_\_\_\_

No

DATE: \_\_\_\_\_ PHYSICIAN SIGNATURE: \_\_\_\_\_

**PENN-HARRIS-MADISON SCHOOL HEALTH SERVICES  
HEALTH QUESTIONNAIRE**

**TO BE ANSWERED BY PARENT**

Name of child \_\_\_\_\_ Date of Birth \_\_\_\_\_

Father \_\_\_\_\_ Mother \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**HISTORY OF ILLNESS, INJURY, SURGERY**

Asthma \_\_\_\_\_

Diabetes \_\_\_\_\_

Seizures \_\_\_\_\_

Heart \_\_\_\_\_

Chicken Pox \_\_\_\_\_

Allergies \_\_\_\_\_

Serious Accident \_\_\_\_\_

Operations \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other \_\_\_\_\_

**Early Development**

This child is \_\_\_\_\_ child in family of  
\_\_\_\_\_ children.

Began to sit up at \_\_\_\_\_ months.

Began to walk at \_\_\_\_\_ months.

Began to say words at \_\_\_\_\_ months.

If your child has any of the following conditions, explain briefly:

Hearing Loss \_\_\_\_\_

Speech Difficulty \_\_\_\_\_

Seizures \_\_\_\_\_

Vision problems \_\_\_\_\_

Is there any condition present that should be considered in planning your child's school program?

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DATE: \_\_\_\_\_ PARENT SIGNATURE: \_\_\_\_\_

**PLEASE HAVE YOUR CHILD'S PHYSICIAN COMPLETE THE OTHER SIDE OF THIS FORM.  
RETURN COMPLETED FORM TO YOUR CHILD'S SCHOOL.**