



CENTRAL COLUMBIA

4777 OLD BERWICK ROAD
BLOOMSBURG, PENNSYLVANIA 17815-3515

District Administration Office
570-784-2850 Ext. 4000
Fax 570-387-0192

High School & Athletic Office
570-784-2850 Ext. 3000
HS Fax 570-784-3570

Middle School Office
570-784-2850 Ext. 2000
Fax 570-784-4935

Elementary School Office
570-784-2850 Ext. 1000
Fax 570-784-2582

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

Heidi Henry RN, BSN, MSN
Middle School

Jan Dubbs RN, BSN, CSN
High School

You can't educate a child who is not healthy, and you can't keep a child healthy who is not educated.
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
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
Last	First	Middle		

ADDRESS

No. and Street	City or Post Office	Borough or Township	County	State	Zip Code
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**MEDICAL HISTORY
IMMUNIZATIONS AND TESTS**

VACCINE	Enter Month, Day, And Year Each Immunization Was Given			BOOSTERS & DATES	
	DOSES				
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	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	
Neuromuscular Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Orthopedic Condition	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory Illness	<input type="checkbox"/>	<input type="checkbox"/>	
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Skin Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Vision Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	

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 _____