pennsylvania
DEPARTMENT OF HEALTH

Bureau of Community Health Systems
Division of School Health

Private or School
PHYSICAL EXAMINATION
OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:

Complete page one of this form before student's exam. Take completed form to appointment.

Student's name ____________________ Today's date____________

Date of birth ____________ Age at time of exam__________ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

____

____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: *Has the student…*	YES	NO
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other__________________		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: *Has the student…*	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: *Has the student...*	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:______________		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: *Has the student...*	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: *Has the student…*	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: *Has the student…*	YES	NO
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. **FEMALES ONLY:** Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? ______ How many periods has she had in the last 12 months? ______ Date of last period: ___________		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: ______________________ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: *Has the student…*	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other______________________		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other______________		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student______________________________ Date____________

Adapted in part from the ***Pre-participation Physical Evaluation History Form***; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes ☐ No ☐

Physical exam for grade: **K/1 ☐ 6 ☐ 11 ☐ Other ☐**	**CHECK ONE** **NORMAL**	 ***ABNORMAL**	 **DEFER**	***ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS**
Height: ( ) inches	☐	☐	☐	
Weight: ( ) pounds	☐	☐	☐	
BMI: ( )	☐	☐	☐	
BMI-for-Age Percentile: ( ) %	☐	☐	☐	
Pulse: ( )	☐	☐	☐	
Blood Pressure: (/)	☐	☐	☐	
Hair/Scalp	☐	☐	☐	
Skin	☐	☐	☐	
Eyes/Vision Corrected ☐	☐	☐	☐	
Ears/Hearing	☐	☐	☐	
Nose and Throat	☐	☐	☐	
Teeth and Gingiva	☐	☐	☐	
Lymph Glands	☐	☐	☐	
Heart	☐	☐	☐	
Lungs	☐	☐	☐	
Abdomen	☐	☐	☐	
Genitourinary	☐	☐	☐	
Neuromuscular System	☐	☐	☐	
Extremities	☐	☐	☐	
Spine (Scoliosis)	☐	☐	☐	
Other	☐	☐	☐	

TUBERCULIN TEST	**DATE APPLIED**	**DATE READ**	**RESULT/FOLLOW-UP**

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam______________20______

Print name of examiner ____

Print examiner's office address____ Phone______________________

Signature of examiner____ MD ☐ DO ☐ PAC ☐ CRNP ☐

STUDENT NAME:

HEALTH CARE PROVIDERS: ***Please photocopy immunization history from student's record – OR – insert information below.***

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued:___________ Reason: ____ Date Rescinded:___________

Medical ☐ Date Issued:___________ Reason: ____ Date Rescinded:___________

Medical ☐ Date Issued:___________ Reason: ____ Date Rescinded:___________

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	**DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization**				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date:__________				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

Page 4 of 4: **ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)**

STUDENT NAME:

pennsylvania
DEPARTMENT OF HEALTH

社区卫生系统局 学校卫生处

学龄学生的
私人机构或学校体检

家长/监护人/学生：

学生体检前，应先完成本表第 1 页的填写。

把填写好的表格交给预约就诊处。

学生姓名 ______________________________ 日期 ______________

出生日期 ______________ 体检时的年龄 ______________ 性别： □ 男 □ 女

药物和过敏：请列出学生目前正在服用的所有处方药、非处方药及补充剂（草药/营养品）：

____

____

学生是否有任何过敏反应？ □ 没有 □ 有（如有，请列出具体的过敏物和过敏反应。）

□ 药物 □ 花粉 □ 食物 □ 叮咬昆虫

填写以下部分，用“√”在“是”或“否”栏中进行标记；对于不确定答案的问题，用圆圈标记。

综合健康状况：*学生是否……*	是	否
1. 有仍在持续的病症？如有，请标出： □哮喘 □贫血 □糖尿病 □感染 其他______________		
2. 曾有留院超过一晚的情况？		
3. 曾做过手术？		
4. 曾有过癫痫发作？		
5. 曾有出生时没有或缺失肾脏、眼睛、睾丸（男性）、脾脏或任何其他器官的病史？		
6. 曾在高温下锻炼时生病？		
7. 锻炼时经常出现肌肉痉挛？		
头部/颈部/脊柱：*学生是否……*	**是**	**否**
8. 锻炼时出现过头痛？		
9. 曾有过头部受伤或脑震荡？		
10. 曾有过头部撞击或打击，并造成过头脑混乱、长期头痛或记忆问题？		
11. 曾在撞击或跌倒后，手臂或腿部出现过麻木、刺痛或无力感？		
12. 曾在撞击或跌倒后，有过无法移动手臂或腿的情况？		
13. 曾注意到或被告知有脊柱弯曲或脊柱侧弯？		
14. 眼睛（视力）出现过任何问题，或有过眼外伤史？		
15. 戴过处方眼镜或隐形眼镜？		
心脏/肺部：*学生是否……*	**是**	**否**
16. 曾使用过吸入器或服用过哮喘药物？		
17. 医生是否说过该男孩（或女孩）有心脏病？如果是，请勾选所有适用项： □心脏杂音或心脏感染 □ 高血压 □川崎病 □ 高胆固醇 □其他______________		
18. 医生是否要求过该男孩（或女孩）做心脏检查？（如心电图（ECG/EKG）、超声心动图）？		
19. 运动**期间**或**运动后**，是否有过咳嗽、喘息、呼吸困难、呼吸急促或头晕的情况？		
20. 运动期间是否有过不适、疼痛、胸闷或胸压的情况？		
21. 运动过程中能感觉到该男孩（或女孩）心跳加速或漏跳？		
骨骼/关节：*学生是否……*	**是**	**否**
22. 曾有过骨折或骨裂、应力性骨折或关节脱位？		
23. 曾有过肌肉、韧带或肌腱受伤？		
24. 曾受伤并需要支架、石膏、拐杖或矫形器的情况？		
25. 曾在受伤后需要拍 x 光片、MRI、CT 扫描、注射或物理治疗？		
26. 曾有过关节疼痛、肿胀、发热或发红的情况？		
皮肤：*学生是否……*	**是**	**否**
27. 曾有过皮疹、褥疮或其他皮肤问题？		
28. 曾有过疱疹或 MRSA 皮肤感染？		

泌尿生殖系统：*学生是否……*	是	否
29. 曾有过腹股沟疼痛或腹股沟区域出现疼痛的隆起或疝？		
30. 曾有尿路感染或尿床史？		
31. **仅限女生**：是否已来月经？ □是 □否 如为“是”：该女生第一次来月经的年龄是多大？________ 过去的 12 个月，该女生一共来过多少次月经？______________ 上次月经的日期：______________		
牙科：	**是**	**否**
32. 学生的牙龈或牙齿是否有过疼痛或问题？		
33. 学生牙医的姓名：______________________________ 上次牙科检查的时间： □不到 1 年 □ 1-2 年 □ 超过 2 年		
社交/学习：*学生是否……*	**是**	**否**
34. 曾被告知有学习障碍、智力或发育障碍、认知延迟、ADD/ADHD 等问题？		
35. 曾被霸凌或经历过霸凌行为？		
36. 经历过重大悲伤、创伤或其他重大的生活事件？		
37. 曾表现出行为、社交关系、成绩、饮食或睡眠习惯的显著变化；远离家人或朋友的情况？		
38. 大多数时候会感到担心、悲伤、沮丧或愤怒？		
39. 表现出精力、动力、兴趣或热情的普遍丧失？		
40. 对体重有顾虑；一直在尝试增重或减肥，或曾收到过增重或减肥的建议？		
41. 曾使用过（或目前正在使用）烟草、酒精或药物？		
家族健康状况：	**是**	**否**
42. 是否有以下家族病史？如果是，请勾选所有适用项： □ 贫血/血液病 □ 遗传性疾病/综合征 □ 哮喘/肺部问题 □ 肾脏问题 □ 行为健康问题 □ 癫痫病 □ 糖尿病 □ 镰状细胞特征或疾病 其他______________________________		
43. 是否有以下心脏相关问题的家族病史？如果是，请勾选所有适用项： □ 布鲁加达综合征 □ QT 综合征 □ 心肌病 □ 马凡氏综合征 □ 高血压 □ 室性心动过速 □ 高胆固醇 □ 其他______________		
44. 是否有任何家庭成员出现过不明原因的晕厥、癫痫发作或差点淹死？		
45. 是否有任何家庭成员/亲属在 50 岁之前死于心脏病或在 50 岁之前意外/不明原因的猝死（包括溺水、不明原因的车祸、婴儿猝死综合症）？		
问题或关切	**是**	**否**
46. 学生、家长或监护人是否有任何问题或关切想与医疗保健提供方讨论？（如有，请在本表第 4 页填写。）		

特此证明，本人已尽我所知，确保所有信息的真实与完整。同意学校护士与医疗保健提供方之间进行健康信息的交换。

家长/监护人/独立的学生签字：______________________________ 日期 ______________

部分内容改编自*《检前身体评估病史表》*；©2010 年美国家庭医生学会、美国儿科学会、美国运动医学院、美国运动医疗医学会、美国骨科运动医学会和美国运动医学骨科学会。

开始检查前，已查阅学生的健康史（本表的第 1 页）：是 □　否 □

体检年级： K/1 □　6 □　11 □ 其他 □	选择其一			*异常发现/建议/转诊
	正常	*不正常	延期检查	
身高：（　）英寸				
体重：（　）磅				
BMI：（　）				
BMI 的同龄百分位数：（　）%				
脉搏：（　）				
血压：（　/　）				
头发/头皮				
皮肤				
眼镜/视力　已矫正 □				
耳部/听力				
鼻、喉				
牙齿和牙龈				
淋巴腺				
心脏				
肺部				
腹部				
泌尿生殖系统				
神经肌肉系统				
四肢				
脊柱（脊柱侧弯）				
其他				

结核菌素试验	申请日期	读取日期	结果/后续

需接受药物治疗、限制活动或可能给教育带来影响的身体状况或慢性病

（更多备注可填写在第 4 页）

体检时，家长/监护人是否在场：是 □　否 □

体检地点：个人医疗保健提供方的办公室 □　学校 □

检查日期：__________20____

检查人员的打印姓名：____________________

检查人员的打印办公地址：____________________　电话：__________

检查人员的签名：____________________　MD □　DO □　PAC □　CRNP □

学生姓名：

医疗保健提供方： ***请复印学生记录中的免疫接种史，或在下方填入信息。***

免疫接种豁免：

医疗 □ 批准日期：____________ 原因：____ 撤销日期：________________

医疗 □ 批准日期：____________ 原因：____ 撤销日期：________________

医疗 □ 批准日期：____________ 原因：____ 撤销日期：________________

注意：对于宗教或哲学原因的接种豁免，家长/监护人必须向学校提出书面申请。

疫苗	**文件：（1）疫苗类型；（2）每次免疫接种的日期（年/月/日）**				
白喉/破伤风/百日咳（儿童）类型：DTaP、DTP 或 DT	1	2	3	4	5
白喉/破伤风/百日咳（青少年/成人） 类型：Tdap 或 Td	1	2	3	4	5
脊髓灰质炎 类型：OPV 或 IPV	1	2	3	4	5
乙型肝炎 (HepB)	1	2	3	4	5
麻疹/腮腺炎/风疹 (MMR)	1	2	3	4	5
经医生诊断的腮腺炎 □	日期：____________________				
水痘：疫苗 □ 出过水痘 □	1	2	3	4	5
血清学检查：（识别抗原/日期/阳性或阴性） 如乙型肝炎、麻疹、风疹、水痘	1	2	3	4	5
脑膜炎球菌结合疫苗 (MCV4)	1	2	3	4	5
人乳头瘤病毒 (HPV) 类型： HPV2 或 HPV4	1	2	3	4	5
流感病毒 类型：TIV（注射） LAIV（鼻腔喷雾）	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
B 型流感嗜血杆菌 (Hib)	1	2	3	4	5
肺炎球菌结合疫苗 (PCV) 类型：7 或 13	1	2	3	4	5
甲型肝炎 (HepA)	1	2	3	4	5
轮状病毒	1	2	3	4	5
其他疫苗：（类型和日期）					

第4页（共4页）：其他备注（监护人/家长/学生/医疗保健提供方）学生姓名：