

The Ijoba Shule
5150 Walnut Street, 3rd Floor
Philadelphia, PA 19139
Phone: (215) 747 - 5737 Fax: (215) 747 - 1185
Primary Care Physician Report

(Please Print Legibly)

Student Information:

Name: _____

Date of Birth: _____ Sex: Male Female

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Grade: _____

Medical History: Immunizations & Tests

Enter Month, Day, and Year each immunization was given in the spaces provided below.

Vaccine	Date Doses Received			Boosters & Dates	
Diphtheria & Tetanus*	1. / /	2. / /	3. / /	4. / /	5. / /
Polio	1. / /	2. / /	3. / /	4. / /	5. / /
Measles, Mumps, Rubella	1. / /	2. / /			
Hepatitis B	1. / /	2. / /	3. / /		
HIB	1. / /	2. / /	3. / /		

* *Diphtheria & Tetanus are usually received in combined vaccines such as DTP, DT, or Td*

- 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

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) _____/_____/_____ (**Attach Copy of Results**).

SIGNIFICANT MEDICAL CONDITIONS		<input checked="" type="checkbox"/> Appropriate Box Below	
	YES	NO	IF YES, EXPLAIN
Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiac/Rheumatic Fever.....	<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"/>	_____
Sickle Cell.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (Specify).....	<input type="checkbox"/>	<input type="checkbox"/>	_____

REPORT OF PHYSICAL EXAMINATION		<input checked="" type="checkbox"/> Appropriate Space Below	
	NORMAL	ABNORMAL	IF ABNORMAL, EXPLAIN
▶ Height (inches)			
▶ Weight (pounds)			
▶ Apical Pulse			
▶ Blood Pressure /			
▶ Hair/Scalp			
▶ Skin			
▶ Eyes: Visual Acuity R _____/_____ L /			
▶ Eyes: Color Vision			
▶ Ears: Hearing dB R L			
▶ Nose & Throat			
▶ Teeth & Gingiva			
▶ Lymph Glands			
▶ Heart ; Murmur, etc.			
▶ Lungs			
▶ Abdomen			
▶ Genitalia			
▶ Neuromuscular System			
▶ Extremities			
▶ Spine			

DATE OF EXAMINATION: _____/_____/_____

Examiner's Signature

Print Name of Examiner

Address

Telephone Number (include area code)