THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES

REPORT OF PHYSICAL EXAMINATION

Name of Student	Date of Birth	Student ID #	Grade
Name of School	Room/Section/Book	Date Issued	

TO THE CARE PROVIDER (Please complete all items)

Pennsylvania law requires that students attending school in the state be immunized and receive periodic medical examinations. Payment for these examinations is the responsibility of the parent/guardian. THESE IMMUNIZATIONS ARE REQUIRED FOR SCHOOL ATTENDANCE. Attach a copy of the student's immunization record, or record the dates below.

VACCINE	ENTER MONTH, DAY, AND YEAR EACH IMMUNIZATION WAS GIVEN DOSES				
Diptheria and Tetanus* (DTap, DTP, Td or DT)	1. / /	2. / /	3. / /	4. / /	5. / /
Polio, (OPV or IPV)	1. / /	2. / /	3. / /	4. / /	
Hepatitis B	1. / /	2. / /	3. / /		
Measles** - Mumps - Rubella (MMR)	1. / /	2. / /	or Measles Serology: Date ______ Titer ______		
Varicella	1. / /	2. / /	Rubella Serology: Date ______ Titer ______		
Other	1. / /	2. / /	Mumps disease diagnosed by a physician: Date ______		

■ Date of last Tetanus Booster____________ ■ Date of last PPD______________ Result____________mm

* One dose must be on or after the fourth (4th) birthday.
** First dose must be on or after the first (1st) birthday and the second dose should be at least one month after the first dose

Does this student have health insurance? ___ Yes ___ No
Name of Insurance Provider:______________________________

RECORD THE FOLLOWING

1. Visual Acuity: Without Glasses: R______ L______ With Glasses: R______ L______
2. Audiometric Screening: R______ L______
3. BP____________
4. Height __________inches / cm Weight __________lb. / kg BMI percentile __________
5. Scoliois Screening: ____ Normal ____ Abnormal ____ Referred ____ No Referral
6. Activity Recommendation: ____ Full Physical Activity ____ Restricted Physical Activity (Must Complete Phys. Ed. Medical Exemption/Program Modification Form MEH-23)
   Specify Restrictions: ____
7. List all medications currently being taken:
   Medication:______________________________ Reason:______________________
8. List ALL problems by history or examination: Circle status of problem
   1. ______________________________ Under Care Care Complete Referred
   2. ______________________________ Under Care Care Complete Referred
   3. ______________________________ Under Care Care Complete Referred

   ____ No Problems Identified

Comments / follow-up treatment plan / Special instructions to school:

Signature of Care Provider (REQUIRED)	Telephone	Care Provider office stamp (REQUIRED)
Address	Date of Exam	

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