

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				
Diphtheria 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.	Scoliosis 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	