

THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES
REPORT OF PHYSICAL EXAMINATION

Name of Student	Date of Birth	Student ID #	Grade
Name of School ARCHBISHOP HYMAN HIGH SCHOOL 11201 ACADEMY ROAD PHILA PA 19153	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.

RECORD OF VACCINE ADMINISTRATION

Please attach complete immunization record including serology results if available.

Allergies _____
 Date of last PPD _____ Result _____ mm

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: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Referred <input type="checkbox"/> No Referral	
6.	Activity Recommendation: <input type="checkbox"/> Full Physical Activity <input type="checkbox"/> Restricted Physical Activity <small>(Must Complete Phys. Ed. Medical Exemption/Program Modification Form MEH-23)</small>	
	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
	<input type="checkbox"/> No Problems Identified	

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

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