THE SCHOOL DISTRICT OF PHILADELPHIA

SCHOOL HEALTH SERVICES

REPORT OF PHYSICAL EXAMINATION

Date Issued: [Date]	Student ID#:

Name of Student:	Date of Birth:	Grade:
Name of School:	Room/Section/Book	

TO THE PARENT/GUARDIAN:

I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.

Parent/Guardian Signature_____Date_____

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: _____ Normal _____Abnormal _____ Referred _____ No Referral
6. Activity Recommendation: _____ Full Physical Activity _____Restricted Physical Activity
   (Must Complete Phys. E. Medical Exemption/Program Modification Form MEH-23)

   Specify Restrictions:_____
7. List all medications currently being taken:

   Medications:_____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 Fax	Care Provider office stamp (REQUIRED)
Address	Date of Exam	