THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES

REPORT OF PHYSICAL EXAMINATION

Name of Student	Date of Birth	Student ID #	Grade
			NEW/ 9/ 11
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		
			/
Varicella			
Other MCV	1. / /	2. / /	Mumps disease diagnosed by a physician: Date

RECORD OF VACCINE ADMINISTRATION

Please attach complete immunization record including serology results if available.

2 doses of varicella required

- ☐ 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	

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