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

| Name of Student | Date of Birth | Student ID # | Grade |
|---|---|---|---|
| | | | |
| Name of School: New Foundations CS | 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.*

2 doses of varicella required

■ 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. 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<br>Fax | Care Provider office stamp (REQUIRED) |
|---|---|---|
| Address | Date of Exam | New Foundations Charter School<br>8001 Torresdale Avenue<br>Philadelphia, PA 19136 |

MEH-1 (Rev. 3/07) Comm. Code 61602445214

THE SCHOOL DISTRICT OF PHILADELPHIA

# Report on Interscholastic Athletic Participation

School Year Ending June: 2019

| Name of Student | Date of Birth | Room/Section/Book | Grade |
|---|---|---|---|
| | | | |

TO THE CARE PROVIDER:

| | Yes | No |
|---|---|---|
| 1. I have examined the student named on this form. (if yes, please report results on other side) | ☐ | ☐ |
| 2. I find this student physically qualified to practice for and participate in ALL competitive games / sports. | ☐ | ☐ |

3. List any special instructions or limitations for sports participation.

| Signature of Care Provider (REQUIRED) | Telephone |
|---|---|
| Address | Date |

To the Parent / Guardian:

1. Does this student have health insurance? Yes ☐ No ☐

| 2. Name of Insurance Provider | | Policy # |
|---|---|---|
| 3. Emergency Contact | Telephone | Relationship |

*I hereby give consent to this student named above to practice for and participate in ALL competitive games / sports . I give my permission for travel to and from these programs. I am fully aware of his / her health condition and limitations, if any. I allow this student to receive any emergency treatment deemed necessary by the medical personnel designated by the program authorities.*

| Signature of Parent / Guardian (REQUIRED) | Telephone |
|---|---|
| Address | Date |