

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 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 <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
	___ 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	