

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 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  |        |  |        |        |
| Diphtheria and Tetanus* (DTap, DTP, Td or DT) | 1. / /   | 2. / / | 3. / /   | 4. / / | 5. / / |
| Polio, (OPV or IPV)                           | 1. / /   | 2. / / | 3. / /   | 4. / / |        |
| Hepatitis B                                   | 1. / /   | 2. / / | 3. / /   |        |        |
| Measles** - Mumps - Rubella (MMR)             | 1. / /   | 2. / / | or Measles Serology: Date _____ Titer _____        |        |        |
| Varicella                                     | 1. / /   | 2. / / | Rubella Serology: Date _____ Titer _____           |        |        |
| Other   | 1. / /   | 2. / / | Mumps disease diagnosed by a physician: Date _____ |        |        |

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<br>(Must Complete Phys. Ed. Medical Exemption/Program Modification Form MEH-23)<br>Specify Restrictions: _____  |               |            |               |          |          |            |               |          |          |            |               |          |
| 7.       | List all medications currently being taken:<br>Medication: _____ Reason: _____   |               |            |               |          |          |            |               |          |          |            |               |          |
| 8.       | List ALL problems by history or examination: _____ Circle status of problem<br><table style="width: 100%; border: none;"> <tr> <td style="width: 60%;">1. _____</td> <td style="width: 10%;">Under Care</td> <td style="width: 10%;">Care Complete</td> <td style="width: 20%;">Referred</td> </tr> <tr> <td>2. _____</td> <td>Under Care</td> <td>Care Complete</td> <td>Referred</td> </tr> <tr> <td>3. _____</td> <td>Under Care</td> <td>Care Complete</td> <td>Referred</td> </tr> </table><br>___ No Problems Identified | 1. _____      | Under Care | Care Complete | Referred | 2. _____ | Under Care | Care Complete | Referred | 3. _____ | Under Care | Care Complete | Referred |
| 1. _____ | Under Care   | Care Complete | Referred   |               |          |          |            |               |          |          |            |               |          |
| 2. _____ | Under Care   | Care Complete | Referred   |               |          |          |            |               |          |          |            |               |          |
| 3. _____ | Under Care   | Care Complete | Referred   |               |          |          |            |               |          |          |            |               |          |

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

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