

THE SCHOOL DISTRICT OF PHILADELPHIA  
**REPORT OF PHYSICAL EXAMINATION**

Name of School	Student ID #	Date Issued	
Name of Student	Date of Birth	Room/Section/Book	Grade

**TO THE CARE PROVIDER**

Pennsylvania law requires that students attending school in the Commonwealth be immunized and receive periodic medical examinations at stated intervals. Participation in sports also requires a physical examination. Payment for these examinations is the responsibility of the parent. Both sides of form must be completed for sports participation. THESE IMMUNIZATIONS ARE REQUIRED FOR SCHOOL ATTENDANCE. Attach a copy of the student's immunization record, or record the dates below. Minimum required doses for **Pennsylvania School Law** are shaded.

VACCINE	Enter Month, Day, and Year Each Immunization Was Given <b>DOSES</b>				
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		

\* One dose must be on or after the fourth birthday.

\*\* First dose must be on or after the first birthday and the second dose should be at least one month after the first dose.

**RECORD THE FOLLOWING**

1. Visual Acuity (Without Glasses)    R ____                    L ____	(With Glasses)    R ____                    L ____
2. Height _____ inches /cm                    Percentile _____	Weight _____ pounds / kg                    Percentile _____
3. Scoliosis Screening    Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	Referred <input type="checkbox"/> No Referral <input type="checkbox"/>
4. Blood Pressure	Audiometric Screening    R ____                    L ____
5. Date of last PPD                    Result _____ mm	Date of last Tetanus Booster _____
6. List all medications currently being taken.	Reason for medication _____
7. Circle any condition this student has or ever had: allergy, asthma, bone fracture or dislocation, congenital abnormality, contacts or glasses, diabetes, epilepsy, head injury, hearing loss, heart trouble or murmur if any. Please specify details, under comments.	
8. Has student ever had any serious illness, injury or operation?    Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please specify details.	

<p>9.                    <b>List other problems at this history or examination</b></p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p>	<b>Status of the Problem</b>		
	Under Care	Care is Complete	Referred

10.     No problems identified

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

Signature of Care Provider (REQUIRED)	Telephone	<b>Care Provider office stamp (REQUIRED)</b>
Address	Date of Exam	

THE SCHOOL DISTRICT OF PHILADELPHIA  
**STUDENT MEDICAL HISTORY**

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

Dear Parent/Guardian:

Pennsylvania law requires that all children must have a complete checkup when entering school for the first time and again in middle and high school.

The school nurse can help you with information regarding health insurance. There are free and low-cost insurance plans for which your family may qualify. Please take the attached form to your doctor or clinic when you take your child for this checkup and return the completed form to the school nurse by \_\_\_\_\_

School Nurse: \_\_\_\_\_

**STUDENT'S MEDICAL HISTORY - TO BE COMPLETED BY PARENT/GUARDIAN**

1. Do you have health insurance?     Yes     No    What is the name of your insurance? \_\_\_\_\_
2. Where do you take your child for checkups? \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
3. Date of child's last physical examination? \_\_\_\_\_
4. Where do you take your child for dental care? \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
5. Date of child's last dental examination? \_\_\_\_\_
6. Does your child take any medicine now?     Yes     No,    If yes, list below:
  - Medicine: \_\_\_\_\_ How often \_\_\_\_\_ For what \_\_\_\_\_
  - Medicine: \_\_\_\_\_ How often \_\_\_\_\_ For what \_\_\_\_\_
  - Medicine: \_\_\_\_\_ How often \_\_\_\_\_ For what \_\_\_\_\_
7. Is your child allergic to anything?     Yes     No, If yes, to what \_\_\_\_\_
8. Does your child have any activity restrictions?     Yes     No, If yes, explain \_\_\_\_\_

**PLEASE CHECK ANY PROBLEM YOUR CHILD HAS/HAS HAD**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Dental             | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Physical Disability           |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Hospitalized (Surgery) | <input type="checkbox"/> Premature Birth (Under 5 Lbs) |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Drug/Alcohol       | <input type="checkbox"/> Learning Problem       | <input type="checkbox"/> Seizures                      |
| <input type="checkbox"/> Behavior/Emotional       | <input type="checkbox"/> Eczema             | <input type="checkbox"/> Lung Disease           | <input type="checkbox"/> Speech Difficulty             |
| <input type="checkbox"/> Blood Disorders          | <input type="checkbox"/> Frequent Colds     | <input type="checkbox"/> Lead Poisoning         | <input type="checkbox"/> Tuberculosis                  |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Hearing Difficulty | <input type="checkbox"/> Meningitis             | <input type="checkbox"/> Vision Problems               |
| <input type="checkbox"/> Chicken Pox at age _____ | <input type="checkbox"/> Heart              | <input type="checkbox"/> Muscle/Bone/Joint      | <input type="checkbox"/> Urinating/Kidney Problem      |

*Additional comments:* \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**THE SCHOOL DISTRICT OF PHILADELPHIA**  
**REPORT OF PRIVATE DENTAL EXAMINATION**

Name of School	Student ID	Date Issued	
Name of Student	Date of Birth	Room/Section/Book	Grade

**TO THE DENTIST**

*Pennsylvania law requires that students attending school in the Commonwealth receive periodic dental examinations at stated intervals (upon original entry, while in third grade, and while in seventh grade).*

*These examinations are required for school attendance. Payment for these examinations is the responsibility of the parent/guardian. If the student/family does not have health insurance the school nurse will help the family apply for health insurance. Please attach a copy of the student's dental examination or record the data below.*

*Thank you for your cooperation.*

UNDER TREATMENT / WORK BEGUN	COMPLETION OF WORK / NO TREATMENT NECESSARY
Date Work Begun	<input type="checkbox"/> No Treatment Required Now
Scheduled Follow-up Appointment	<input type="checkbox"/> All Necessary Dental Work Completed
Date of Dental Examination	Expected Completion Date

*Comments / Follow-up Treatment / Special Instructions to School*

Name of Dentist	Telephone
Signature of Dentist	Date Signed
Address	Fax Number

**IMPORTANT:**

**Return this form to:**

\_\_\_\_\_ Certified School Nurse/Practitioner

\_\_\_\_\_ School

\_\_\_\_\_ School Address

\_\_\_\_\_ Phone Number