

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:                         | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Referred <input type="checkbox"/> No Referral |   |
| 6.  | Activity Recommendation:                     | <input type="checkbox"/> Full Physical Activity <input type="checkbox"/> 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  |
| <input type="checkbox"/> No Problems Identified |  |  |   |

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

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