

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

Date Issued: [Date]

Student ID#:

Name of Student:

Date of Birth:

Grade:

Name of School:

Room/Section/Book

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

Activity Recommendation: _____ Full Physical Activity _____ Restricted Physical Activity

(Must Complete Phys. E. Medical Exemption/Program Modification Form MEH-23)

6. Specify Restrictions: _____

7. List all medications currently being taken:

Medications: _____ Reason: _____

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

Care Provider office stamp (REQUIRED)

Fax

Address

Date of Exam