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 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		

* 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 ☐ Abnormal ☐	Referred ☐ No Referral ☐
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 ☐ No ☐
If yes, please specify details.

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

10. ☐ No problems identified

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

Signature of Care Provider (REQUIRED)	Telephone	**Care Provider office stamp** (REQUIRED)
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

___ Asthma	___ Dental	___ High Blood Pressure	___ Physical Disability
___ Anemia	___ Diabetes	___ Hospitalized (Surgery)	___ Premature Birth (Under 5 Lbs)
___ Arthritis	___ Drug/Alcohol	___ Learning Problem	___ Seizures
___ Behavior/Emotional	___ Eczema	___ Lung Disease	___ Speech Difficulty
___ Blood Disorders	___ Frequent Colds	___ Lead Poisoning	___ Tuberculosis
___ Cancer	___ Hearing Difficulty	___ Meningitis	___ Vision Problems
___ Chicken Pox at age___	___ Heart	___ Muscle/Bone/Joint	___ 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	☐ No Treatment Required Now
Scheduled Follow-up Appointment	☐ 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