

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.

<b>RECORD OF VACCINE ADMINISTRATION</b> <i>(Please attach complete immunization record including serology results if available)</i>
--

Allergies \_\_\_\_\_     
  Date of last PPD \_\_\_\_\_ Result \_\_\_\_\_ mm

Does this student have health insurance?  Yes  No      Name of Insurance Provider: \_\_\_\_\_

<b>RECORD THE FOLLOWING</b>
-----------------------------

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  
 (Must Complete Phys. E. Medical Exemption/Program Modification Form MEH-23)  
 Specify Restrictions: \_\_\_\_\_

7. List all medications currently being taken:  
 Medications: \_\_\_\_\_ 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

\_\_\_\_\_ 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	