

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: ___ Normal ___ Abnormal ___ Referred ___ No Referral												
6.	Activity Recommendation: ___ Full Physical Activity ___ 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 <table style="width: 100%; border: none;"> <tr> <td style="width: 60%;">1. _____</td> <td style="width: 15%;">Under Care</td> <td style="width: 15%;">Care Complete</td> <td style="width: 10%;">Referred</td> </tr> <tr> <td>2. _____</td> <td>Under Care</td> <td>Care Complete</td> <td>Referred</td> </tr> <tr> <td>3. _____</td> <td>Under Care</td> <td>Care Complete</td> <td>Referred</td> </tr> </table> ___ No Problems Identified	1. _____	Under Care	Care Complete	Referred	2. _____	Under Care	Care Complete	Referred	3. _____	Under Care	Care Complete	Referred
1. _____	Under Care	Care Complete	Referred										
2. _____	Under Care	Care Complete	Referred										
3. _____	Under Care	Care Complete	Referred										

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	