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 healthcare provider and my health care provider to reply as needed regarding my child’s careParent/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 parent/guardian. THES IMMUNUNIZATIONS ARE REQUIRED FOR SCHOOL ATTENDANCE**.** |
| **RECORD OF VACCINE ADMINISTRATION****Please attach complete immunization record including serology results if available** |
| * **Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of 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 \_\_\_\_\_\_\_\_
 |
| 1. Audiometric Screening: R \_\_\_\_\_\_ L \_\_\_\_\_\_\_
 | 1. BP \_\_\_\_\_\_\_\_
 |
| 1. 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. Ed. Medical Exemption/Program Modification form MEH-23  Specify Restrictions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  7. List all medications currently taken: Medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  8. List ALL problems by history or examination Circle status of problem1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Under Care Care Complete Referred

 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Under Care Care Complete Referred
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Under Care Care Complete Referred

 \_\_\_\_\_\_\_ No Problems Identified |
| Comments/follow-up treatment plan/Special instructions in school |
| Signature of Care Provider (REQUIRED) | TelephoneFax | Care Provider office stamp (REQUIRED) |
| Address | Date of Exam |