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 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 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 problem   1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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) | | Telephone  Fax | Care Provider office stamp (REQUIRED) | |
| Address | | Date of Exam | | |