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 _____
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. 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
   2. _____ Under Care Care Complete Referred
   3. _____ 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	