

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
	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	