THE SCHOOL DISTRICT OF PHILADELPHIA

SCHOOL HEALTH SERVICES

REPORT OF PHYSICAL EXAMINATION

Date Issued: [Date]	Student ID#:

Name of Student:	Date of Birth:	Grade:
Name of School:	Room/Section/Book	

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
   (Must Complete Phys. E. Medical Exemption/Program Modification Form MEH-23)

   Specify Restrictions:_____
7. List all medications currently being taken:

   Medications:_____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 Fax	Care Provider office stamp (REQUIRED)
Address	Date of Exam	

THE SCHOOL DISTRICT OF PHILADELPHIA

STUDENT MEDICAL HISTORY

Name of Student	Date of Birth	Date
Name of School	**Room/Book/Section**	**Grade**

Dear Parent/Guardian:

Pennsylvania law requires that all children must have a complete checkup when entering school for the first time and again in middle and high school.

The school nurse can help you with information regarding health insurance. There are free and low-cost insurance plans for which your family may qualify. Please take the attached form to your doctor or clinic when you take your child for this checkup and return the completed form to the school nurse by_____

School Nurse: _____

STUDENT'S MEDICAL HISTORY - TO BE COMPLETED BY PARENT/GUARDIAN

1. Do you have health insurance? ___ Yes ___ No What is the name of your insurance?_____
2. Where do you take your child for checkups?_____ Phone:_____ Fax: _____
3. Date of child's last physical examination?_____
4. Where do you take your child for dental care? _____ Phone:_____ Fax: _____
5. Date of child's last dental examination?_____
6. Does your child take any medicine now? ___ Yes ___ No, If yes, list below:
   - Medicine: _____ How often _____ For what _____
   - Medicine: _____ How often _____ For what _____
   - Medicine: _____ How often _____ For what _____
7. Is your child allergic to anything? ___ Yes ___ No, If yes, to what_____
8. Does your child have any activity restrictions? ___ Yes ___ No, If yes, explain_____

PLEASE CHECK ANY PROBLEM YOUR CHILD HAS/HAS HAD

__ Asthma	__ Dental	__ High Blood Pressure	__ Physical Disability
__ Anemia	__ Diabetes	__ Hospitalized (Surgery)	__ Premature Birth (Under 5 Lbs)
__ Arthritis	__ Drug/Alcohol	__ Learning Problem	__ Seizures
__ Behavior/Emotional	__ Eczema	__ Lung Disease	__ Speech Difficulty
__ Blood Disorders	__ Frequent Colds	__ Lead Poisoning	__ Tuberculosis
__ Cancer	__ Hearing Difficulty	__ Meningitis	__ Vision Problems
__ Chicken Pox at age___	__ Heart	__ Muscle/Bone/Joint	__ Urinating/Kidney Problem

*Additional comments:*_____

_____

_____

THE SCHOOL DISTRICT OF PHILADELPHIA

REPORT OF PRIVATE DENTAL EXAMINATION

Name of School	Student ID	Date Issued	
Name of Student	Date of Birth	Room/Section/Book	Grade

TO THE DENTIST

Pennsylvania law requires that students attending school in the Commonwealth receive periodic dental examinations at stated intervals (upon original entry, while in third grade, and while in seventh grade).

These examinations are required for school attendance. Payment for these examinations is the responsibility of the parent/guardian. If the student/family does not have health insurance the school nurse will help the family apply for health insurance. Please attach a copy of the student's dental examination or record the data below.

Thank you for your cooperation.

UNDER TREATMENT / WORK BEGUN	**COMPLETION OF WORK / NO TREATMENT NECESSARY**
Date Work Begun	☐ No Treatment Required Now
Scheduled Follow-up Appointment	☐ All Necessary Dental Work Completed
Date of Dental Examination	Expected Completion Date

Comments / Follow-up Treatment / Special Instructions to School

Name of Dentist	Telephone
Signature of Dentist	Date Signed
Address	Fax Number

IMPORTANT:

Return this form to:

_____
Certified School Nurse/Practitioner

_____
School

_____
School Address

_____
Phone Number