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	

MEH-1 (Rev. 2/17)