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_____

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. Ed. Medical Exemption/Program Modification Form MEH-23)
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 Fax	Care Provider office stamp (REQUIRED)
Address	Date of Exam	