

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	