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 (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	

MEH-1 (Rev. 11/12) Comm. Code 61602445214