

COMMONWEALTH OF PENNSYLVANIA
PENNSYLVANIA DEPARTMENT OF HEALTH
SCHOOL PERSONNEL HEALTH RECORD

I. Patient Information

Last Name	First	MI	Sex	D.O.B.
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Social Security Number	Home Telephone	Work Telephone
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Mailing Address	Street	City	Zip
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Usual Source of Medical Care	Physician's Name	Address	Telephone
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Emergency Contact - Name	Relationship	Address	Telephone
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II. Immunization History

VACCINE	Enter Month, Day, and Year Each Immunization was Given						BOOSTERS & DATES								
	DOSES														
Diphtheria and Tetanus*	1	/	/	2	/	/	3	/	/	4	/	/	5	/	/
Hepatitis B	1	/	/	2	/	/	3	/	/						
Measles, Mumps, Rubella	1	/	/	2	/	/									
Other _____	/ /			Other _____					/ /						
*Tetanus and Diphtheria are usually received in combined vaccines such as DTP, DTaP, DT or Td															

III. Required Tuberculosis Test Results (as per Regulations of the Department of Health)

Date Applied	Arm	Method	Antigen	Manufacturer	Signature
Date Read	Results (mm)		Signature		

For previously known/new positive reactors: _____

Chest X-ray: Date: _____ Results: _____ Other: Date: _____ Results: _____
(Attach a copy of the report.) (Attach a copy of the report.)

Preventive Anti-Tuberculosis - Chemotherapy ordered: ☐ No ☐ Yes Date: _____

IF SIGNIFICANT REACTION WAS REPORTED, THE PHYSICIAN REPORT MUST STATE THAT THE APPLICANT IS FREE FROM CURRENT TUBERCULOSIS DISEASE OR IS UNDER ADEQUATE CHEMOTHERAPY FOR TUBERCULOSIS DISEASE. _____

IV. Significant Medical Conditions (✓)

	Yes	No	If Yes, Explain
Allergies	☐	☐	
Asthma.....	☐	☐	
Cardiac.....	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus.....	☐	☐	
Gastrointestinal Disorder.....	☐	☐	
Hearing Disorder	☐	☐	
Hypertension	☐	☐	
Neuromuscular Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder.....	☐	☐	
Vision Disorder	☐	☐	
Other (Specify)	☐	☐	

V. Report of Physical Examination (✓)

	Normal	Abnormal	Not Examined	Comments
• Height (inches)				
• Weight (pounds)				
• Pulse				
• Blood Pressure /				
• Hair/Scalp				
• Skin				
• Eyes — Visual Acuity R / L /				
• Eyes — Color Vision				
• Ears — Hearing dB R L				
• Nose and Throat				
• Teeth and Gingiva				
• Lymph Glands				
• Heart — Murmur, etc.				
• Lung — Adventitious Findings				
• Abdomen				
• Genitourinary				
• Neuromuscular System				
• Extremities				

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her work role? If so, specify _____

Physician Name (Print) Signature of Examiner Date

Physician Address

The statements and answers as recorded above are full, complete and true to the best of my knowledge and belief. I understand that any false or misleading statements may cause termination of my employment.

I authorize the physician or other person to disclose any knowledge or information pertaining to my health to the employing authority for whom this examination is performed.

Signature of Employee Date