

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>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.</i> Parent/Guardian Signature _____ Date _____													
RECORD OF VACCINE ADMINISTRATION <i>Please attach complete immunization record including serology results if available.</i>													
■ 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.	<table style="width: 100%; border: none;"> <tr> <td style="width: 60%;">List ALL problems by history or examination:</td> <td style="width: 40%; text-align: center;">Circle status of problem</td> </tr> <tr> <td>1. _____</td> <td style="text-align: center;">Under Care Care Complete Referred</td> </tr> <tr> <td>2. _____</td> <td style="text-align: center;">Under Care Care Complete Referred</td> </tr> <tr> <td>3. _____</td> <td style="text-align: center;">Under Care Care Complete Referred</td> </tr> <tr> <td colspan="2">_____ No Problems Identified</td> </tr> </table>			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	
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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											