

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 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 <small>(Must Complete Phys. Ed. Medical Exemption/Program Modification Form MEH-23)</small> 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	Care Provider office stamp (REQUIRED)
	Fax	
Address	Date of Exam	

THE SCHOOL DISTRICT OF PHILADELPHIA
Report on Interscholastic Athletic Participation

School Year Ending June: _____

Name of Student	Date of Birth	Room/Section/Book	Grade
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TO THE CARE PROVIDER:

- | | | | |
|---|--------------------------|--------------------------|--|
| | <u>Yes</u> | <u>No</u> | |
| 1. I have examined the student named on this form.
(if yes, please report results on other side) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. I find this student physically qualified to practice for
and participate in ALL competitive games / sports. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. List any special instructions or limitations for sports participation. | | | |

Signature of Care Provider (REQUIRED)	Telephone
Address	Date

To the Parent / Guardian:

1. Does this student have health insurance? Yes No

2. Name of Insurance Provider	Policy #
3. Emergency Contact	Relationship
Telephone	

I hereby give consent to this student named above to practice for and participate in ALL competitive games / sports . I give my permission for travel to and from these programs. I am fully aware of his / her health condition and limitations, if any. I allow this student to receive any emergency treatment deemed necessary by the medical personnel designated by the program authorities.

Signature of Parent / Guardian (REQUIRED)	Telephone
Address	Date