THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES

REPORT OF PHYSICAL EXAMINATION

Date Issued: [Date]		Student ID#:
Name of Student:	Date of Birth:	Grade:
Name of School: The Philadelphia High School for Girls	Room/Section/Book	

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. E. Medical Exemption/Program Modification Form MEH-23)
   Specify Restrictions:____
7. List all medications currently being taken:
   Medications:________________________________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. 2/17)