

THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES
REPORT OF PHYSICAL EXAMINATION

Date Issued: [Date]		Student ID#:
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: 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	