Position			

## COMMONWEALTH OF PENNSYLVANIA PENNSYLVANIA DEPARTMENT OF HEALTH

## SCHOOL PERSONNEL HEALTH RECORD

I. Patient Information					<u> </u>	
Last Name	First		MI	Sex	Date of Birth	
Social Security Number	_		Home Telephone		Work Telephone	
Mailing Address	Street		City		State Zip	
Usual Source of Medical	Care Physic	ian's Name	Address		Telephone	
Emergency Contact – Name Relationship		Addr	Address			
II. Immunization Histor	у		T invest			
VACCINE	Enter M	onth, Day, and Year Eacl	n Immunization was Given	ROOSTI	ERS & DATES	
Diphtheria and Tetanus*	1.	2.	3.	4.	5.	
Hepatitis B	1.	2.	3.			
Measles, Mumps, Rubel	la 1.	2.				
Other	1.	Other	I de la companya del companya de la companya del companya de la co	1.		
* Tetanus and Diphtheria are us				Health		
DATE APPLIED	ARM	METHOD	ANTIGEN	MANUFACTURER	SIGNATURE	
DATE READ	RESUI	LTS (mm)		SIGNATURE		
For previously known/ne	w positive reactor	rs:				
	1	Results:		Results of the report.)		
Preventive Anti-Tubercul	osis Chemothera	py ordered:	☐ No ☐ Yes	Date:		
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IV. Significant Medical Conditions (*	<u> </u>				
	Yes	No	If Yes, Explain:		
Allergies					
Asthma					
Cardiac					
Chemical Dependency					
Drugs			9		
Alcohol					
Diabetes Mellitus					
Gastrointestinal Disorder					
Hearing Disorder	Ц	Ц			
Hypertension		닏			
Neuromuscular Disorder	$\vdash$				
Orthopedic Condition	님	H			
Respiratory Illness	님	H			υ
Seizure Disorder	H	H			
Skin Disorder	H	H	-		
Other (Specify)	H	H	-		
Other (Specify)					
V. Report of Physical Examination (	<b>√</b> )				
		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			<b>-</b>		
Lymph Glands				-	
Heart – Murmur, etc					
Lungs – Adventitous Findings					
Abdomen					
Genitourinary					
Neuromuscular System					
Extremities					
Are there any special medical problems or specify			n require restriction o	f activity, medicati	on or which might affect his/her work role? If so,
Physician Name (Print)		<del></del> :	Q;	gnature of Examine	er Date
rnysician ivanie (rimi)			Si,	gnature of Examine	5 S
		P	hysician Address		
The statements and answers as recorded ab statements may cause termination of my en	ove are	full, complete ent.	and true to the best of	of my knowledge ar	nd belief. I understand that any false or misleading
I authorize the physician or other person to examination is performed.	disclose	e any knowled	ge or information per	rtaining to my heal	th to the employing authority for whom this
		P	Cian -t	f Employee	Date
			Signature of	r Embroyee	Date