Position _____

COMMONWEALTH OF PENNSYLVANIA
PENNSYLVANIA DEPARTMENT OF HEALTH

SCHOOL PERSONNEL HEALTH RECORD

I. Patient Information

M ◯ F ◯

Last Name	First	MI	Sex	Date of Birth

Social Security Number	Home Telephone	Work Telephone

Mailing Address	Street Address	City	State	Zip

Usual Source of Medical Care	Physician's Name	Address	Telephone

Emergency Contact – Name	Relationship	Address	Telephone

II. Immunization History

VACCINE	Enter Month, Day, and Year Each Immunization was Given DOSES			BOOSTERS & DATES	
Diphtheria and Tetanus*	1.	2.	3.	4.	5.
Hepatitis B	1.	2.	3.		
Measles, Mumps, Rubella	1.	2.			
Other _____	1.	Other _____		1.	

***** Tetanus and Diphtheria are usually received in combined vaccines such as DTP, DtaP, DT, or Td

III. Required Tuberculosis Test Results (as per Regulations of the Department of Health

DATE APPLIED	ARM	METHOD	ANTIGEN	MANUFACTURER	SIGNATURE

DATE READ	RESULTS (mm)	SIGNATURE

For previously known/new positive reactors: _____

Chest X-ray: Date: _____ Results: _____ (Attach a copy of the report.)

Other: Date: _____ Results: _____ (Attach a copy of the report.)

Preventive Anti-Tuberculosis Chemotherapy ordered: ☐ No ☐ Yes Date: _____

IF SIGNIFICANT REACTION WAS REPORTED, THE PHYSICIAN REPORT MUST STATE THAT THE APPLICANT IS FREE FROM CURRENT TUBERCULOSIS DISEASE OR IS UNDER ADEQUATE CHEMOTHERAPY FOR TUBERCULOSIS DISEASE:

_____
_____
_____

IV. Significant Medical Conditions (✓)

	Yes	No	If Yes, Explain:
Allergies	☐	☐	
Asthma	☐	☐	
Cardiac	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder	☐	☐	
Hypertension	☐	☐	
Neuromuscular Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder	☐	☐	
Other (Specify)	☐	☐	

V. Report of Physical Examination (✓)

	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	☐	☐	☐	
Lymph Glands	☐	☐	☐	
Heart – Murmur, etc…	☐	☐	☐	
Lungs – Adventitous Findings	☐	☐	☐	
Abdomen	☐	☐	☐	
Genitourinary	☐	☐	☐	
Neuromuscular System	☐	☐	☐	
Extremities	☐	☐	☐	

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her work role? If so, specify _____

_____ _____ _____

Physician's Name (Print) Signature of Examiner Date

_____

Physician's Address

The statements and answers as recorded above are full, complete and true to the best of my knowledge and belief. I understand that any false or misleading statements may cause termination of my employment.

I authorize the physician or other person to disclose any knowledge or information pertaining to my health to the employing authority for whom this examination is performed.

_____ _____

Signature of Employee Date