Position _____

COMMONWEALTH OF PENNSYLVANIA
PENNSYLVANIA DEPARTMENT OF HEALTH

# SCHOOL PERSONNEL HEALTH RECORD

## I. Patient Information

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 | 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 Name (Print) Signature of Examiner Date

_____

Physician 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