

THE SCHOOL DISTRICT OF PHILADELPHIA  
**REPORT OF PHYSICAL EXAMINATION**

Name of School	Student ID #	Date Issued	
Name of Student	Date of Birth	Room/Section/Book	Grade

**TO THE CARE PROVIDER**

Pennsylvania law requires that students attending school in the Commonwealth be immunized and receive periodic medical examinations at stated intervals. Participation in sports also requires a physical examination. Payment for these examinations is the responsibility of the parent. Both sides of form must be completed for sports participation.

THESE IMMUNIZATIONS ARE REQUIRED FOR SCHOOL ATTENDANCE. Attach a copy of the student's immunization record, or record the dates below. Minimum required doses for **Pennsylvania School Law** are shaded.

VACCINE	Enter Month, Day, and Year Each Immunization Was Given <b>DOSES</b>				
Diphtheria and Tetanus* (DTap, DTP, Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /
Polio, (OPV or IPV)	1 / /	2 / /	3 / /	4 / /	
Hepatitis B	1 / /	2 / /	3 / /		
Measles** - Mumps - Rubella (MMR)	1 / /	2 / /	or Measles Serology:      Date                      Titer		
Varicella	1 / /	2 / /	Rubella Serology:      Date                      Titer		
Other	1 / /	2 / /	Mumps disease diagnosed by a physician:      Date		

\* One dose must be on or after the fourth birthday.

\*\* First dose must be on or after the first birthday and the second dose should be at least one month after the first dose.

**RECORD THE FOLLOWING**

1. Visual Acuity (Without Glasses)      R____      L____	(With Glasses)      R____      L____
2. Height _____ inches /cm      Percentile _____	Weight _____ pounds / kg      Percentile _____
3. Scoliosis Screening      Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	Referred <input type="checkbox"/> No Referral <input type="checkbox"/>
4. Blood Pressure	Audiometric Screening      R____      L____
5. Date of last PPD      Result _____ mm	Date of last Tetanus Booster _____
6. List all medications currently being taken.	Reason for medication _____

7. Circle any condition this student has or ever had: allergy, asthma, bone fracture or dislocation, congenital abnormality, contacts or glasses, diabetes, epilepsy, head injury, hearing loss, heart trouble or murmur if any. Please specify details, under comments.

8. Has student ever had any serious illness, injury or operation?      Yes       No   
 If yes, please specify details.

9. List other problems at this history or examination	Status of the Problem		
	Under Care	Care is Complete	Referred
1. _____			
2. _____			
3. _____			

10.  No problems identified

Comments / follow - up treatment plan / Special instructions to school

Signature of Care Provider (REQUIRED)	Telephone	<b>Care Provider office stamp (REQUIRED)</b>
Address	Date of Exam	

THE SCHOOL DISTRICT OF PHILADELPHIA  
 Report on Interscholastic Athletic Participation

School Year Ending June: \_\_\_\_\_

Name of Student	Date of Birth	Room/Section/Book	Grade
-----------------	---------------	-------------------	-------

TO THE CARE PROVIDER:

- |   |                          |                          |  |
|---|--------------------------|--------------------------|--|
|   | <u>Yes</u>               | <u>No</u>                |  |
| 1. I have examined the student named on this form.<br>(if yes, please report results on other side)               | <input type="checkbox"/> | <input type="checkbox"/> |  |
| 2. I find this student physically qualified to practice for<br>and participate in ALL competitive games / sports. | <input type="checkbox"/> | <input type="checkbox"/> |  |
| 3. List any special instructions or limitations for sports participation.   |                          |                          |  |
| _____   |                          |                          |  |
| _____   |                          |                          |  |
| _____   |                          |                          |  |
| _____   |                          |                          |  |

Signature of Care Provider (REQUIRED)	Telephone
---------------------------------------	-----------

Address	Date
---------	------

To the Parent / Guardian:

1. Does this student have health insurance?                      Yes                       No

2. Name of Insurance Provider	Policy #
-------------------------------	----------

3. Emergency Contact	Telephone	Relationship
----------------------	-----------	--------------

*I hereby give consent to this student named above to practice for and participate in ALL competitive games / sports . I give my permission for travel to and from these programs. I am fully aware of his / her health condition and limitations, if any. I allow this student to receive any emergency treatment deemed necessary by the medical personnel designated by the program authorities.*

Signature of Parent / Guardian (REQUIRED)	Telephone
---	-----------

Address	Date
---------	------