Position	

COMMONWEALTH OF PENNSYLVANIA PENNSYLVANIA DEPARTMENT OF HEALTH SCHOOL PERSONNEL HEALTH RECORD

1. Patient Information	on									
					=					
Last Name		First			MI		Sex	Date of Birth		
Social Security Numb	er	Н			Home Teleph	ome Telephone		Work Telephone		
Mailing Address		Street			City			State	Zip	
Jsual Source of Medi	cal Care	e Physician's Name		Jame	Address		Telephone			
Emergency Contact –	Name	me Relationship		tionship		Address		Telephone		
I. Immunization His	story									
VACCINE		Enter Month, Day, and Year Each In DOSES						OSTERS & DATES		
Diphtheria and Tetar	nus*	19		2.	3.		4.	5.		
Hepatitis B		1.		2.	3.					
Measles, Mumps, Ru	ıbella	1, 2		2.						
Other		1. Other				1.				
II. Required Tubero		<u> </u>		· Regulations		tment of	Health MANUFACTURER	SIGNA	ATURE	
DATE ATTLIED		AKINI		METHOD	Anti	IGEN	MANUFACTURER	Sidita	HUKE	
DATE READ		RESULTS (mm)				SIGNATURE				
For previously known	/new po	sitive reacto	rs:							
Chest X-ray: Date Attach a copy of the 1			Results	: <u></u>			of the report.)	s:		
reventive Anti-Tuber	rculosis	Chemothera	py orde	ered:	□ No □	Yes	Date:	<u> </u>		
							ST STATE THAT THE A			

IV. Significant Medical Conditions (<					
	Yes N	0	If Yes, Explain:		
Allergies] ,			
Asthma]			
Cardiac] [
Chemical Dependency]			
Drugs]			
Alcohol]			
Diabetes Mellitus]			
Gastrointestinal Disorder] ,			
Hearing Disorder]			
Hypertension] ,			
Neuromuscular Disorder]			
Orthopedic Condition					
Respiratory Illness		<u> </u>			
Seizure Disorder					
Skin Disorder		ļ			
Vision Disorder		ļ			
Other (Specify)		ļ			
V. Report of Physical Examination (✓))				
	NOR	MAL	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 chrospecify	onic diseases	which	require restriction of	f activity, medication	on or which might affect his/her work role? If so,
Physician Name (Print)		_	Sig	nature of Examine	r Date
		Phy	ysician Address		-
The statements and answers as recorded above statements may cause termination of my emplo		iplete a	nd true to the best of	my knowledge an	d belief. I understand that any false or misleading
I authorize the physician or other person to dis examination is performed.	close any kn	owledge	e or information pert	aining to my healt	n to the employing authority for whom this
			Signature of	Employee	Date