H511.340 (Rev. 4/00)

Position		
POSITION		

## COMMONWEALTH OF PENNSYLVANIA PENNSYLVANIA DEPARTMENT OF HEALTH

## SCHOOL PERSONNEL HEALTH RECORD

I. Patient Information	on									
Last Name		First		ľ	MI		Sex	Date of Birt	Date of Birth	
Social Security Numb	er		Но			elephone		Work Telep	Work Telephone	
Mailing Address		Street				City		State Zip		
Usual Source of Medi	cal Care	e Physician's Name		ame		Address		Telephone		
Emergency Contact –	Name	me Relationship		tionship		Address		Telephone		
II. Immunization His	story									
		Enter M	onth, Day	y, and Year Each	Immuniza	tion was Given				
VACCINE	*	<del> </del>		DOSES		,		BOOSTERS & DATES		
Diphtheria and Tetar	ius*	1.		2.		3. 3.	4.	5.		
Hepatitis B  Measles, Mumps, Ru	ıballa	1.		2.	-	).				
Other	iociia	1.		Other	_		1.			
* Tetanus and Diphtheria an							Health			
DATE APPLIED	1	ARM	N	METHOD		ANTIGEN	MANUFACTURER	SIGNA	TURE	
DATE READ		RESULTS (mm)			SIGNATURE					
For previously known	/new po	ositive reactor	rs:							
Chest X-ray: Date (Attach a copy of the	e: report.)		Results:	:		Other: Date: (Attach a copy	of the report.)	ts:		
Preventive Anti-Tuber	rculosis	Chemothera	py orde	red: [	] No	Yes	Date:			
							ST STATE THAT THE A			

IV. Significant Medical Conditions (✓)					
	Yes	No	If Yes, Explain:		
Allergies					
Asthma					
Cardiac					
Chemical Dependency					
Drugs					
Alcohol					
Diabetes Mellitus	Ц	Ц			
Gastrointestinal Disorder	Ц	Ц			
Hearing Disorder	닏	$\sqcup$			
Hypertension	Ц	$\sqcup$			
Neuromuscular Disorder	닏	$\sqcup$			
Orthopedic Condition	닏	$\vdash$			
Respiratory Illness	닏	$\sqcup$			
Seizure Disorder	닏	$\vdash$	·		
Skin Disorder	닏	$\vdash$	·		
Vision Disorder	닏	님			
Other (Specify)	Ш	Ш			
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 chrospecify	onic o	diseases which	n require restriction of	f activity, medicati	on or which might affect his/her work role? If so,
Dhysician North (Brint)			u.	matura of E	D-4-
Physician Name (Print)			Sig	gnature of Examine	er Date
		P	hysician Address		
The statements and answers as recorded above statements may cause termination of my employed			and true to the best of	f my knowledge an	nd belief. I understand that any false or misleading
I authorize the physician or other person to dis examination is performed.	sclose	any knowled	ge or information per	taining to my healt	h to the employing authority for whom this
			Signature of	Employee	
			Digitature Of	Limpioyee	Date