THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES

REPORT OF PHYSICAL EXAMINATION

Name of Student	Date of Birth	Student ID #	Grade
Name of School: Our Lady of Fort Pechin	Room/Section/Book	Date Issued	

TO THE PARENT/GUARDIAN:

I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.

Parent/Guardian Signature_____ Date_____

RECORD OF VACCINE ADMINISTRATION

Please attach complete immunization record including serology results if available.

■ Allergies_____ ■ Date of last PPD_____ Result_____mm

Does this student have health insurance?_____Yes_____No Name of Insurance Provider:_____

RECORD THE FOLLOWING

1. Visual Acuity: Without Glasses: R_____ L_____ With Glasses: R_____ L_____

2. Audiometric Screening: R_____ L_____

3. BP _____

4. Height_____inches / cm Weight_____lb. / kg BMI percentile _____

5. Scoliosis Screening: _____Normal _____Abnormal _____Referred _____No Referral

6. Activity Recommendation:_____Full Physical Activity _____Restricted Physical Activity
(Must Complete Phys. Ed. Medical Exemption/Program Modification Form MEH-23)
Specify Restrictions: _____

7. List all medications currently being taken:
Medication:_____Reason:_____

8. List ALL problems by history or examination:

	Circle status of problem		
1. _____	Under Care	Care Complete	Referred
2. _____	Under Care	Care Complete	Referred
3. _____	Under Care	Care Complete	Referred

_____ No Problems Identified

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

Signature of Care Provider (REQUIRED)	Telephone Fax	Care Provider office stamp (REQUIRED)
Address	Date of Exam	

MEH-1 (Rev. 7/19)

THE SCHOOL DISTRICT OF PHILADELPHIA

REPORT OF PRIVATE DENTAL EXAMINATION

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

TO THE DENTIST

Pennsylvania law requires that students attending school in the Commonwealth receive periodic dental examinations at stated intervals (upon original entry, while in third grade, and while in seventh grade).

These examinations are required for school attendance. Payment for these examinations is the responsibility of the parent/guardian. If the student/family does not have health insurance the school nurse will help the family apply for health insurance. Please attach a copy of the student's dental examination or record the data below.

Thank you for your cooperation.

UNDER TREATMENT / WORK BEGUN	COMPLETION OF WORK / NO TREATMENT NECESSARY
Date Work Begun	☐ No Treatment Required Now
Scheduled Follow-up Appointment	☐ All Necessary Dental Work Completed
Date of Dental Examination	Expected Completion Date
Comments / Follow-up Treatment / Special Instructions to School	

Name of Dentist	Telephone
Signature of Dentist	Date Signed
Address	Fax Number

IMPORTANT:

Return this form to:

M. Karpinski RN, BSN, M.Ed., CSN
Certified School Nurse/Practitioner

Our Lady of Port Richmond
School

3233 Thompson Street
School Address

215-739-1920
Phone Number