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 **DOSES**				
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 ☐ Abnormal ☐ | Referred ☐ No Referral ☐
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	**Care Provider office stamp** (REQUIRED)
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:

	Yes	No
1. I have examined the student named on this form. (if yes, please report results on other side)	☐	☐
2. I find this student physically qualified to practice for and participate in ALL competitive games / sports.	☐	☐

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