H511.340 (rev. 6/97)

Position _____

COMMONWEALTH OF PENNSYLVANIA
PENNSYLVANIA DEPARTMENT OF HEALTH

SCHOOL PERSONNEL HEALTH RECORD

1. **Patient Information**

Last Name	First	MI	Sex	D.O.B.

Social Security Number	Home Telephone	Work Telephone

Mailing Address	Street	City	Zip

Usual Source of Medical Care	Physician's Name	Address	Telephone

Emergency Contact - Name	Relationship	Address	Telephone

II. **Immunization History**

VACCINE	Enter Month, Day, and Year Each Immunization was Given DOSES			BOOSTERS & DATES	
Diphtheria and Tetanus*	1 / /	2 / /	3 / /	4 / /	5 / /
Hepatitis B	1 / /	2 / /	3 / /		
Measles, Mumps, Rubella	1 / /	2 / /			
Other_____	/ /	Other_____		/ /	
*Tetanus and Diphtheria are usually received in combined vaccines such as DTP, DTaP, DT or Td					

Ill. **Required Tuberculosis Test Results (as per Regulations of the Department of Health)**

Date Applied	Ann	Method	Antigen	Manufacturer	Signature
Date Read	Results (mm)		Signature		

For previously known/new positive reactors: _____

Chest X-ray: Date: _____ Results: _____ Other:Date: _____ Results: _____
(Attach a copy of the report.) (Attach a copy of the report.)

Preventive Anti-Tuberculosis - Chemotherapy ordered: ☐ No ☐ Yes Date: _____

IF SIGNIFICANT REACTION WAS REPORTED, THE PHYSICIAN REPORT MUST STATE THAT THE APPLICANT IS FREE FROM CURRENT TUBERCULOSIS DISEASE OR IS UNDER ADEQUATE CHEMOTHERAPY FOR TUBERCULOSIS DISEASE. _____

IV. **Significant Medical Conditions (V)**

	Yes	No	If Yes, Explain
Allergies	☐	☐	
Asthma	☐	☐	
Cardiac	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder	☐	☐	
Hypertension	☐	☐	
Neuromuscular Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder	☐	☐	
Other (Specify)	☐	☐	

V. Report of Physical Examination (V) Date of Examination: _____

	Normal	Abnormal	If Abnormal, Explain
• Height (inches)			
• Weight (pounds)			
• Pulse ( )			
• Blood Pressure /			
• Hair/Scalp			
• Skin _____ _____			
• Eyes - Visucal Acuity R / L /			
• Eyes - Color Vision			
• Ears - Hearing dB R L			
• Nose and Throat			
• Teeth and Gingiva			
• Lymph Glands			
• Heart - Murmur, etc.			
• Lung - Adventious Findings			
• Abdomen			
• Genitalia ...			
• Neuromuscular System			
• Extremities			

Is there any mental, emotional or physical condition for which the individual should remain under your medical care: (,/) ☐NO ☐YES Comments: _____

_____ _____

Signature of Examiner Physician Name (Print)

_____

Physician Address

The statements and answers as recorded above are full, complete and true to the best of my knowledge and belief. I understand that any false or misleading statements may cause termination of my employment.

I authorize the physician or other person to disclose any knowledge or information pertaining to my health to the employing authority for whom this examination is performed.

_____ _____

Signature of Employee Date