H511.340 (Rev. 4/00)

Position ____________________

COMMONWEALTH OF PENNSYLVANIA
PENNSYLVANIA DEPARTMENT OF HEALTH

SCHOOL PERSONNEL HEALTH RECORD

I. Patient Information

Last Name ______ First ______ MI ______ Sex ______ Date ofBirth ______

Social Security Number ______ Home Telephone ______ Work Telephone ______

Mailing Address ______ Street ______ City ______ State ______ Zip ______

Usual Source of Medical Care ______ Physician's Name ______ Address ______ Telephone ______

Emergency Contact-Name ______ Relationship ______ Address ______ Telephone ______

U. Immunization History

Enter Mouth, Day, and Year Each Immunization was Given

VACCINE	DOSES			BOOSTERS & DATES	
Diphtheria and Tetanus*	1.	2.	3.	4.	5.
Hepatitis B	1.	2.	3.		
Measles, Mumps, Rubella	1.	2.			
Other ______	1.	Other ______	______	1.	

*Tetanus and Diphtheria are usually received in combined vaccines such as DTP, DtaP, DT, or Td

ID. Required Tuberculosis Test Results Cas per Regulations of the Denartment of Health

DATE APPLIED	ARM	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: O No O 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 (¢)

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

Y. Report ofPhysical Examination (¢)

	NORMAL	ABNORMAL	NOT EXAMINED	COMMENTS
Height (inches)				
Weight (pounds)				
Pulse				
Blood Pressure				
Hair/Scalp				
Slcin				
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 chronic diseases which require restriction of activity, medication or which might affect his/her work role? If so, specizy ______________________________

______________________________ Physician Name (Print)

______________________________ Signature of Examiner

______________ Date

______________________________ 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