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 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 | | | | | |

## III. Required Tuberculosis Test Results (as per Regulations of the Department 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: ☐ 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 (✓)

| | 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 (✓)

| | Normal | Abnormal | Not Examined | Comments |
|---|---|---|---|---|
| • 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 | | | | |
| • 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, specify ____________________

______________________ ______________________ ______________
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