## COMMONWEALTH OF PENNSYLVANIA PENNSYLVANIA DEPARTMENT OF HEALTH SCHOOL PERSONNEL HEALTH RECORD

I. Patient Information	on														
Last Name	First			MI				Sex			D.O.B.				
Social Security Number		Home Telephone									Wor	k Tele <sub>l</sub>	phone		
Mailing Address		Street					City				2	Zip			
Usual Source of Medical Care		Physician's Name					Address				Telephone				
Emergency Contact - Name		Relationship						Address						Teleph	none
II. Immunization Hi	story														
		Ent	er Mo	onth, Day,	and Y		ach Immu	nizatio	on wa	s Given	Τ				
VACCINE Diphtheric and Tetanya*		1		/	2	DOS /		3	/	/	A	BOC /		$\frac{S \& DA}{5}$	
Diphtheria and Tetanus*		1			2		1	3	/		4			3 /	
Hepatitis B		1	/		2			3							
Measles, Mumps, Rubella Other		1			-						Т				
		L	/	/		her_					L	/	/		
*Tetanus and Diphther	are usually	recei	ved 1	n combin	ed va	accin	es such as	s DT	P, D'	FaP, DT (	or T	ď			
III. Required Tuber	culosis Test	Resu	ults (	as per l	Regu	latio	ns of th	e De	par	tment of	f H	ealth	)		
Date Applied	Arm			Method				Antigen			Manufacturer			Signa	ture
Date Read	Results (mm)				_	Signature									
For previously known/	new positive	e reac	ctors	:											
Chest X-ray:Date:(Atta	Rach a copy o				Othe	er: Da				Results of the	-				
Preventive Anti-Tuber	culosis - Ch	emot	hera	py order	ed:		□ No		) Y	es	Da	ite: _			
IF SIGNIFICANT RE APPLICANT IS FREI CHEMOTHERAPY F	E FROM CU	RRE	ENT	TUBER	CUL										E

## IV. Significant Medical Conditions (✓)

Yes	No If Yes	s, 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 D ( 6D) 1 1D (10/4)				
V. Report of Physical Examination (✓)				
			DT-4	
	Normal	Abnormal	Not Examined	Comments
• Height (inches)	MOLINAL	ADDIOLIBRE	Examined	Comments
• Weight (pounds)	-			•
• Pulse	<u> </u>			
	-			
• 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.				
<ul> <li>Lung — Adventious Findings</li> </ul>				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Are there any special medical problems or chro	nic diseases	which requi	re restriction	of activity, medication or wh
might affect his/her work role? If so, specify		•		•
Physician Name (Print)	Sign	ature of Exa	miner	Date
	Physician	Address		
The statements and answers as recorded above				
understand that any false or misleading stateme	nts may cau	se termination	on of my em	ployment.
I authorize the physician or other person to disc	lose any kn	owledge or i	nformation 1	pertaining to my health to the
employing authority for whom this examination				
•	_			
Signature of Employee				Date