Position	

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

L. Patient Informatio	n		=======================================	-					
Last Name		First			I	Sex	Date of Birth		
Social Security Number F					ome Telephone		Work Telephone		
Mailing Address		Stree	1		City		State	Zip	
J	Anning : todated				01.7		State	Zip	
Usual Source of Medical Care Phys			hysician's Name			ess	Telephone		
Emergency Contact - Name Relati			tionship Address			Telephone			
I. Immunization His	tory		* 100					£5	
VACCINE		Enter I	Month, Da	y, and Year Each Ir DOSES	nmunization was Given	BOOSTE	BOOSTERS & DATES		
Diphtheria and Tetan	us*	1. 2.			3.	4.	5.		
Hepatitis B		1.		2.	3.	HISTORY III AND COLOR		Z T	
Measles, Mumps, Rubella		1.	1. 2.					4 × -	
Other	her		Other			1.			
II. Required Tuberc		est Result		Regulations o	f the Department of  ANTIGEN	Health MANUFACTURER	SIGNA	TURE	
DATE DE AD		BEOLUTO ()				OVGNA TUDO			
DATE READ		RESULTS (mm)			SIGNATURE				
For previously known/	new pos	sitive reacto	ors:						
Chest X-ray: Date: Results: Results:				:	Other: Date: Results: (Attach a copy of the report.)				
Preventive Anti-Tubero	culosis (	Chemother	apy orde	red:	No Yes	Date:			
F SIGNIFICANT REA	ACTION ULOSIS	N WAS RE S DISEASE	PORTE OR IS	D, THE PHYSI UNDER ADEQ	CIAN REPORT MUS DUATE CHEMOTHE	ST STATE THAT THE AP	PLICANT IS I	FREE FRO	
			70.						

IV. Significant Medical Conditions (v	<u> </u>						
	Yes	No	If Yes, Explain:				
Allergies			Promiss				
Asthma	H	Ħ					
Cardiac		Ħ		7,000			
Chemical Dependency							
Drugs					***************************************		
Alcohol							
Diabetes Mellitus				INCOUNTED TO THE PROPERTY OF T			
Gastrointestinal Disorder							
Hearing Disorder							
Hypertension				1000/100			
Neuromuscular Disorder							
Orthopedic Condition							
Respiratory Illness							
Seizure Disorder	Щ	Ц					
Skin Disorder	$\sqcup$	$\sqcup$					
Vision Disorder		$\sqcup$					
Other (Specify)	Ш	Ш					
V. Report of Physical Examination (	<u>&lt;)                                    </u>						
		NORMAL	ABNORMAL	NOT EXAMINED	COMMENTS		
Height (inches)		<del></del>		D.M.M. (LD	***		
Weight (pounds)					- <del> </del>		
Pulse							
Blood Pressure							
Hair/Scalp							
Skin	<del></del>	•		<del></del>			
Eyes – Visual Acuity: R L	_						
Eyes - Color Vision							
Ears - Hearing (dB) R L							
Nose and Throat	_	<del></del>					
<del></del>	-						
Teeth and Gingiva							
Lymph Glands		<del></del>					
Heart - Murmur, etc							
Lungs - Adventitous Findings							
Abdomen							
Genitourinary		•					
Neuromuscular System							
Extremities							
Are there any special medical problems or cl specify	hronic d	liseases which	require restriction of	activity, medication or v	which might affect his/her work role? If so,		
Physician Name (Print)  Signature of Examiner  Date							
<del></del>		Pt	nysician Address				
The statements and answers as recorded abostatements may cause termination of my emp	ve are fi ploymer	ull, complete :	and true to the best of	my knowledge and belie	ef. I understand that any false or misleading		
I authorize the physician or other person to dexamination is performed.	lisclose	any knowledg	ge or information perta	aining to my health to the	e employing authority for whom this		

Signature of Employee

Date