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	DOB

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: _____ (Attach a copy of the report.) Other: Date: _____ Results: _____ (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. Significant Medical Conditions (✓)

	Normal	Abnormal	Not Examined	Comments
• Height (inches)				
• Weight (pounds)				
• Pulse				
• Blood Pressure /				
• Hair/Scalp				
• Skin				
• Eyes –Visual 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