THE SCHOOL DISTRICT OF PHILADELPHIA
REPORT OF PRIVATE DENTAL EXAMINATION

Name of School	Student ID	Date Issued	
Name of Student	Date of Birth	Room/Section/Book	Grade

TO THE DENTIST

Pennsylvania law requires that students attending school in the Commonwealth receive periodic dental examinations at stated intervals (upon original entry, while in third grade, and while in seventh grade). These examinations are required for school attendance. Payment for these examinations is the responsibility of the parent/guardian. If the student/family does not have health insurance the school nurse will help the family apply for health insurance. Please attach a copy of the student's dental examination or record the data below. Thank you for your cooperation.

Under Treatment/Work Begun	Completion of Work/No Treatment Necessary
Date work Begun	☐ No Treatment Required now
Scheduled Follow-up Appointments	☐ All Necessary Dental Work Completed
Date of Dental Examination	Expected Completion Date

Comments/follow - up treatment/Special Instructions to School

Name of Dentist	Telephone
Signature of Dentist	Date Signed
Address	Fax Number

IMPORTANT:
Return this form to:

Certified School Nurse/Practitioner

School

School Address

Phone Number

THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES
REPORT OF PHYSICAL EXAMINATION

Name of Student	Date of Birth	Student ID #	Grade

Name of School	Room/Section/Book	Date Issued

TO THE CARE PROVIDER (Please complete all items)

Pennsylvania law requires that students attending school in the state be immunized and receive periodic medical examinations. Payment for these examinations is the responsibility of the parent/guardian. THESE IMMUNIZATIONS ARE REQUIRED FOR SCHOOL ATTENDANCE.

RECORD OF VACCINE ADMINISTRATION

Please attach complete immunization record including serology results if available.

☐ Allergies _____ ☐ Date of last PPD_____ Result_____mm

Does this student have health insurance? ___ Yes ___ No Name of Insurance Provider:_____

RECORD THE FOLLOWING

1. Visual Acuity: Without Glasses: R_____ L_____ With Glasses: R_____ L_____
2. Audiometric Screening: R_____ L_____ 3. BP_____
4. Height _____inches / cm Weight _____lb. / kg BMI percentile _____
5. Scoliosis Screening: ____ Normal ____ Abnormal ____ Referred ____ No Referral
6. Activity Recommendation: ____ Full Physical Activity ____ Restricted Physical Activity
   (Must Complete Phys. Ed. Medical Exemption/Program Modification Form MEH-23)
   Specify Restrictions: _____
7. List all medications currently being taken:
   Medication:_____ Reason:_____
8. List ALL problems by history or examination: Circle status of problem
   1. _____ Under Care Care Complete Referred
   2. _____ Under Care Care Complete Referred
   3. _____ Under Care Care Complete Referred
   ____ No Problems Identified

Comments / follow-up treatment plan / Special instructions to school:

Signature of Care Provider (REQUIRED)	Telephone Fax	Care Provider office stamp (REQUIRED)
Address	Date of Exam	