

THE SCHOOL DISTRICT OF PHILADELPHIA
REPORT OF PHYSICAL EXAMINATION

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

TO THE CARE PROVIDER

Pennsylvania law requires that students attending school in the Commonwealth be immunized and receive periodic medical examinations at stated intervals. Participation in sports also requires a physical examination. Payment for these examinations is the responsibility of the parent. Both sides of form must be completed for sports participation. THESE IMMUNIZATIONS ARE REQUIRED FOR SCHOOL ATTENDANCE. Attach a copy of the student's immunization record, or record the dates below. Minimum required doses for **Pennsylvania School Law** are shaded.

VACCINE	Enter Month, Day, and Year Each Immunization Was Given				
	DOSES				
Diphtheria and Tetanus* (DTap, DTP, Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /
Polio, (OPV or IPV)	1 / /	2 / /	3 / /	4 / /	
Hepatitis B	1 / /	2 / /	3 / /		
Measles** - Mumps - Rubella (MMR)	1 / /	2 / /	or Measles Serology: Date _____ Titer _____		
Varicella	1 / /	2 / /	Rubella Serology: Date _____ Titer _____		
Other	1 / /	2 / /	Mumps disease diagnosed by a physician: Date _____		

* One dose must be on or after the fourth birthday.

** First dose must be on or after the first birthday and the second dose should be at least one month after the first dose.

RECORD THE FOLLOWING

1. Visual Acuity (Without Glasses) R _____ L _____	(With Glasses) R _____ L _____
2. Height _____ inches /cm Percentile _____	Weight _____ pounds / kg Percentile _____
3. Scoliosis Screening Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	Referred <input type="checkbox"/> No Referral <input type="checkbox"/>
4. Blood Pressure _____	Audiometric Screening R _____ L _____
5. Date of last PPD _____ Result _____ mm	Date of last Tetanus Booster _____
6. List all medications currently being taken.	Reason for medication _____
7. Circle any condition this student has or ever had: allergy, asthma, bone fracture or dislocation, congenital abnormality, contacts or glasses, diabetes, epilepsy, head injury, hearing loss, heart trouble or murmur if any. Please specify details, under comments.	
8. Has student ever had any serious illness, injury or operation? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please specify details.	

9. List other problems at this history or examination	Status of the Problem		
		Under Care	Care is Complete
	Referred		
	1. _____		
2. _____			
3. _____			

10. No problems identified

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

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

THE SCHOOL DISTRICT OF PHILADELPHIA
Report on Interscholastic Athletic Participation

School Year Ending June: _____

Name of Student	Date of Birth	Room/Section/Book	Grade
-----------------	---------------	-------------------	-------

TO THE CARE PROVIDER:

- | | | | |
|---|--------------------------|--------------------------|--|
| | <u>Yes</u> | <u>No</u> | |
| 1. I have examined the student named on this form.
(if yes, please report results on other side) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. I find this student physically qualified to practice for
and participate in ALL competitive games / sports. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. List any special instructions or limitations for sports participation. | | | |
| _____ | | | |
| _____ | | | |
| _____ | | | |
| _____ | | | |

Signature of Care Provider (REQUIRED)	Telephone
---------------------------------------	-----------

Address	Date
---------	------

To the Parent / Guardian:

1. Does this student have health insurance? Yes No

2. Name of Insurance Provider	Policy #
-------------------------------	----------

3. Emergency Contact	Telephone	Relationship
----------------------	-----------	--------------

I hereby give consent to this student named above to practice for and participate in ALL competitive games / sports . I give my permission for travel to and from these programs. I am fully aware of his / her health condition and limitations, if any. I allow this student to receive any emergency treatment deemed necessary by the medical personnel designated by the program authorities.

Signature of Parent / Guardian (REQUIRED)	Telephone
---	-----------

Address	Date
---------	------

SECTION 3: HEALTH HISTORY

Explain "Yes" answers at the bottom of this form.
Circle questions you don't know the answers to.

	Yes	No		Yes	No
1. Has a doctor ever denied or restricted your participation in sport(s) for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	22. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing medical condition (like asthma or diabetes)?	<input type="checkbox"/>	<input type="checkbox"/>	23. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a doctor ever told you that you have (check all that apply):			30. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur			31. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection			32. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	33. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	34. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	36. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
14. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	37. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, that caused you to miss a practice or Contest? If yes, circle affected area below:	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	41. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	42. Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
Head Neck Shoulder Upper arm Elbow Forearm Hand/ Fingers Chest			43. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
Upper back Lower back Hip Thigh Knee Calf/shin Ankle Foot/ Toes			44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	45. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	46. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
			FEMALES ONLY		
			47. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
			48. How old were you when you had your first menstrual period?	_____	_____
			49. How many periods have you had in the last 12 months?	_____	_____
			50. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

No(s).	Explain "Yes" answers here:

I hereby certify that to the best of my knowledge all of the information herein is true and complete.
 Student's Signature _____ Date ____/____/____
 I hereby certify that to the best of my knowledge all of the information herein is true and complete.
 Parent's/Guardian's Signature _____ Date ____/____/____

(please turn page over)