Port Allegany SCHOOL DISTRICT

INSTRUCTION SHEET FOR COMPLETION OF SCHOOL PERSONNEL HEALTH RECORD

Please check the following items after the physician completes your medical form.
ALL AREAS MUST BE COMPLETED.

Please indicate the **"Position"** for which you are applying, as requested at the top right-hand corner of the form.

I. **PATIENT INFORMATION** (to be completed by employee)

II. **IMMUNIZATION HISTORY**
If immunization history is not obtainable, physician may indicate on his stationery ***"TO THE BEST OF MY KNOWLEDGE, (INSERT PATIENT'S NAME) IS FREE FROM COMMUNICABLE DISEASE."***

III. **REQUIRED TUBERCULOSIS TEST RESULTS (to be completed by physician)**

A. A current tuberculin test is required. The test cannot be older than **ONE (1) YEAR.**

B. Do not submit the medical form until the test results are recorded.

IV. **SIGNIFICANT MEDICAL CONDITIONS**

V. **REPORT OF PHYSICIAN EXAMINATION**

A. Date of Examination

B. Each category must be checked either "NORMAL" or "ABNORMAL". A short explanation is requested for abnormal.

The examiner must sign the medical form. The **PHYSICIAN'S** name and address should be printed.

Your signature and date of signature are required at the bottom of the medical form.

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PLEASE SUBMIT THE COMPLETED SCHOOL PERSONNEL HEALTH RECORD TO THE OFFICE OF HUMAN RESOURCES . IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE OFFICE OF HUMAN RESOURCES AT 724-548-6059 OR 724-548-6057.

H511.340 (8/2011) Position _____

COMMONWEALTH OF PENNSYLVANIA
PENNSYLVANIA DEPARTMENT OF HEALTH

SCHOOL PERSONNEL HEALTH RECORD

I. Patient Information

Last Name	First	MI	Sex	Date of Birth
Social Security Number		Home Telephone		Work Telephone
Mailing Address	Street		City	State 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 _____	1.	Other _____		1.	

* 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. Report of Physical Examination (✓)

	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…				
Lungs – Adventitous 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