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

Last Name	Ei-n+			١n					п				0 D			
Lasi name	First	MI				Sex				D.O.B.						
Social Security Number			Home Telephone								***	Wo	rk Tele	phone		
Mailing Address			Street						City						Zìp	
Usual Source of Medical Care			Physician's Name						Address				Telephone			
Emergency Contact - Name		Relationship						Address						Teleph	one	
II. Immunization His	story									•		···				
VACCINE			Enter Month, Day, and Year Each Imm DOSES						unization was Given				BOOSTERS & DATES			
Diphtheria and Tetan	us*	1	1	1	2	1	1	3	I	/	4		/	5 /		
Hepatitis B		1	1	1	2	1	1	3	1	1			****			
Measles, Mumps, Rubella		1	1	/	2	t	/									
Other		/ / Other						/ / /					1			
*Tetanus and Diphthari	ia are usually	rece	ived i	in combi	ned v	accin	es such	as DT	P, D	ГаР, DT	or T	d				
III. Required Tubere	culosis Test	Res	ults	(as per	Regu	llatio	ns of t	the De	epar	tment o	f H	ealth	i).			
Date Applied	Arm		Method				Antigen Man				nufac	ufacturer Signatu			ше	
Date Read	F	Results (Uts (mm)				Siş				gnature			
	***************************************		-	****						,,,,,,,,,						
For previously known	new positiv	e rea	ctors	;		<u>_</u>	~~							***************************************		
Chest X-ray:Date:																
(Att	ach a copy o	of the	сз	ort.)	_O.M.C	AL	(At	tach a	copy	y of the	repo	rt.)	•			
Preventive Anti-Tuber	culosis - Ch	emo	thera	py orde:	red:] No		ĴΥ	es	Da	te: _				
IF SIGNIFICANT RE APPLICANT IS FREI CHEMOTHERAPY F	E FROM CU	IRRI	ENT	TUBER	CUI	LOSI	S DISE	EASE	OR:	IS UND	IST ER	STA ADI	TE TH EQUA'	IAT TH FE	E	

IV. Significant Medical Conditions (\checkmark)

Yes	No If Y	es, Explain		
Allergies				
Asthma				
Cardiac				
Chemical Dependency	Ц			
Drugs	닐	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·	
Alcohol	<u> </u>			
Diabetes Mellitus	닐			
Gastrointestinal Disorder	님 —			
Hearing Disorder	님 —			
Hypertension	님			
Neuromuscular Disorder	닠			
Orthopedic Condition	님 —			
Respiratory Illness	片 —			
Seizure Disorder	├ ─			
Skin Disorder	片 —		· · · · · · · · · · · · · · · · · · ·	
	片-			
Other (Specify)	Ч			
V. Report of Physical Examination (1)				
	Normal	Abnormal	Not Examined	Comments
Height (inches)				
Weight (pounds)				
• Pulse				
• Blood Pressure /		- 		
Hair/Scalp				
• Skin			<u> </u>	
• Eyes — Visucal Acuity R / L /	<u> </u>			
• Eyes — Color Vision				
• Ears — Hearing dB R L				
Nose and Throat				
• Teeth and Gingiva		1		
• Lymph Glands		- 		
Heart — Murmur, etc.				
			<u> </u>	
• Lung — Adventious Findings				
• Abdomen				
Genitourinary				
Neuromuscular System	1			
• Extremities	<u> </u>	<u> </u>	<u> </u>	
Are there any special medical problems or chromight affect his/her work role? If so, specify	nic disease	s which requi		of activity, medication or which
Physician Name (Print)	Sig	nature of Exa	mmer	Date
	Physicia	n Address	- A - 414 - 4740444	
The statements and answers as recorded above a understand that any false or misleading statements				
I authorize the physician or other person to disc employing authority for whom this examination			nformation p	pertaining to my health to the
Signature of Employee	•			Date
DISTURBLE OF PHILIPPACE				240