H511.340 (Rev. 5/2019)

COMMONWEALTH OF PENNSYLVANIA
PENNSYLVANIA DEPARTMENT OF HEALTH
SCHOOL PERSONNEL HEALTH RECORD
(FOR USE AFTER OFFER OF EMPLOYMENT HAS BEEN MADE)

I INFORMATION School Position Offered _____

Last Name First MI Sex Date of Birth

Home Phone Cell Phone Work Phone

Mailing Address: Street City State Zip

Emergency Contact Name: Relationship: Address:

Telephone number: (Home) (Work) (Cell)

II. IMMUNIZATION HISTORY (Recommended, but not mandated by law)

VACCINE Check appropriate box	**Enter Month, Day, and Year Each Immunization DOSE Was Given**				
Diphtheria, Tetanus with Pertussis ☐Td ☐TdaP	1	2	3	4	5
Hepatitis B	1	2	3		
Measles-Mumps-Rubella (MMR)	1	2	Rubella Serology/Date/Titer		
Varicella ☐ Vaccine ☐ Disease ☐ Serology Date: Neg / Pos	1	2	Mumps disease diagnosed by a physician: Date Measles Serology/Date/Titer		
Influenza	1	2	3		

III. TUBERCULOSIS SKIN TEST RESULTS (Testing required per Regulations of the Department of Health)

DATE GIVEN	**SITE: LA / RA**	**GIVEN BY:**	**ANTIGEN NAME**	**MANUFACTURER / LOT # / EXP DATE**	**SIGNATURE**

DATE READ	**RESULTS in MM**	**READ BY SIGNATURE**

IGRA TEST RESULTS **OR**

DATE COLLECTED	**TEST NAME (QFT-GIT, T-SPOT, etc)**	**POSITIVE**	**NEGATIVE**	**INDETERMINATE**	**QUANTITATIVE RESULT**

DATE TEST COMPLETED _____ **SIGNATURE** _____

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 PRIMARY CARE PROVIDER REPORT MUST STATE THAT THE APPLICANT IS CURRENTLY FREE FROM TUBERCULOSIS DISEASE.

IV. 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. PHYSICAL EXAMINATION (✓)

	NORMAL	ABNORMAL	NOT EXAMINED	COMMENTS
Height (inches)				
Weight (pounds)				
Pulse				
Blood Pressure				
Hair/Scalp				
Skin				
Eyes – Visual Acuity: RL				
Eyes – Color Vision				
Ears – Hearing (dB) RL				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart – Murmur, etc…				
Lungs – Adventious Findings				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				

Are there any special medical problems or chronic diseases which require restriction of activity, medication which might affect his/her work role? If so, specify:

Are there any special equipment or accommodations needed to enable this person to perform their duties? 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