

COMMONWEALTH OF PENNSYLVANIA
PENNSYLVANIA DEPARTMENT OF HEALTH
SCHOOL PERSONNEL HEALTH RECORD

I. Patient Information

Last Name _____ First _____ MI _____ Sex _____ DOB _____

Social Security Number _____ Home telephone _____ Work Telephone _____

Mailing Address _____ Street _____ City _____ 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 _____	/ /	Other _____		/ /	
* 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: _____ Other: Date: _____ Results: _____
(Attach a copy of the report.) (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. _____

