

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. _____

