

COMMONWEALTH OF PENNSYLVANIA
PENNSYLVANIA DEPARTMENT OF HEALTH
SCHOOL PERSONNEL HEALTH RECORD

I. Patient Information

Last Name First MI Sex D.O.B.

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. _____

