

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**

**IF AVAILABLE**

VACCINE	Enter Month, Day, and Year Each Immunization Was Given			BOOSTERS & DATES	
	DOSES				
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. \_\_\_\_\_

