

COMMONWEALTH OF PENNSYLVANIA
PENNSYLVANIA DEPARTMENT OF HEALTH
SCHOOL PERSONNEL HEALTH RECORD

I. Patient Information

Last Name	First	MI	Sex	Date of Birth
Social Security Number		Home Telephone		Work Telephone
Mailing Address	Street	City	State	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			BOOSTERS & DATES	
	DOSES			4.	5.
Diphtheria and Tetanus*	1.	2.	3.	4.	5.
Hepatitis B	1.	2.	3.		
Measles, Mumps, Rubella	1.	2.			
Other _____	1/	Other _____		1.	

* 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:

