

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			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

\*\*\*If you no longer have a record of having obtained childhood immunizations, but are reasonably sure you obtained them, initial here:  
\_\_\_\_\_

**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. \_\_\_\_\_

