



## **LOWER MERION SCHOOL DISTRICT**

301 E. Montgomery Avenue, Ardmore, PA 19003-3399  
Phone 610-645-1931 Fax 610-645-9536 [www.lmsd.org](http://www.lmsd.org)

### **NOTICE FOR SCHOOL PERSONNEL HEALTH RECORD FORM**

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits employers and other entities covered by GINA title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when completing this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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

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

**IV. Significant Medical Conditions (✓)**

	Yes	No	If Yes, Explain
Allergies .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiac.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemical Dependency.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes Mellitus.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuromuscular Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthopedic Condition .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory Illness .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (Specify) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____

**V. Report of Physical Examination (✓)**

	Normal	Abnormal	Not Examined	Comments
• Height (inches)				
• Weight (pounds)				
• Pulse				
• Blood Pressure /				
• Hair/Scalp				
• Skin				
• Eyes — Visucal Acuity R / L /				
• Eyes — Color Vision				
• Ears — Hearing dB R L				
• Nose and Throat				
• Teeth and Gingiva				
• Lymph Glands				
• Heart — Murmur, etc.				
• Lung — Adventitious Findings				
• Abdomen				
• Genitourinary				
• Neuromuscular System				
• Extremities				

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her work role? If so, specify \_\_\_\_\_

\_\_\_\_\_  
Physician Name (Print)

\_\_\_\_\_  
Signature of Examiner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Address

The statements and answers as recorded above are full, complete and true to the best of my knowledge and belief. I understand that any false or misleading statements may cause termination of my employment.

I authorize the physician or other person to disclose any knowledge or information pertaining to my health to the employing authority for whom this examination is performed.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date