Office of Field Services
102 Stevens Hal
814.393.2144

Student's name_____ Student ID _____

Telephone number_____

Birthdate_____

Please indicate that the following is complete on the School Personnel Health Record.

_____ Patient Information
Immunization History
_____ Requirements- Hepatitis B (3 doses or proven immunity by titers)
MMR (2 doses or proven immunity by titers)
Diphtheria and Tetanus (last dose must be within the past 9 years)
_____ Tuberculosis Test Result-Valid for 2 years. Must be read in millimeters and interpretation must follow the CDC guidelines.

Date read for:
CSD Student 2 Step _____
Education Student 1 Step_____

_____ Significant Medical Conditions

_____ Physical Examination

I certify that to the best of my knowledge the information, statements, answers, and sections above are full, complete, and true.

_____ _____
Physician Signature Date

Physicians Name (Print) _____

Medical Licensure No. _____

Name of Practice _____

Address _____ Phone_____

_____

_____