DISTRICT 205
EMPLOYEE HEALTH EXAMINATION

PLEASE PRINT OR TYPE (Information on this form may be shared with appropriate personnel for health employment purposes.)

NAME ______________________________ DATE OF BIRTH ____/____/____ SEX ___M ___F
Last First Middle Month Day Year

ADDRESS ______________________________ APT. ___ HOUSE ___ PHONE __________
Street City Zip

MEDICAL HISTORY (To be completed by Employee)

TB/TB Contact Year __________
Congenital Defects __________
Diabetes __________
Epilepsy/Seizure Disorder __________
Heart Diseases __________
Injuries/Accidents __________
Year __________
Results ______________________________

____
(SIGNATURE OF EMPLOYEE) (Date)

Permanent Disability Year __________
Type ______________________________
Results ______________________________
Surgery (Operations) Year __________
Type ______________________________
Results ______________________________
Allergies (List) ______________________________
Routine Medications (List) ______________________________
____

PHYSICAL EXAMINATION (To be completed by Physician)

HEIGHT __________
WEIGHT

	Normal	Abnormal	Follow-Up Comments
General Appearance			
Skin			
Head			
Neck			
Eyes			
Ears			
Nose			
Mouth/Teeth			
Throat			
Glands			
Heart			
B/P			
Pulse Rate			
Gastrointestinal			
Genitourinary			
Neurological			
Other			

	Date	Normal	Abnormal
Hemoglobin			
Hematocrit			
Urinalysis			

Medications __________
____

Allergies __________
____

Other __________
____

Overall Assessment
____
____
____
____

TB Skin Test ______ Results ______
Chest X Ray ______ Results ______

Are you immunized against:

Rubella (3-day or German measles) ______yes ______no
Diphtheria and Tetanus (TD or Td) ______yes ______no
*Last date ______________

*Booster required every ten years.

PHYSICIAN'S SIGNATURE ______________________________ DATE __________

ADDRESS ______________________________ PHONE __________