SCHOOL PERSONNEL HEALTH RECORD (FOR USE AFTER OFFER OF EMPLOYMENT HAS BEEN MADE)

I. INFORMATION

ered							
First	MI	\$	Sex	Date of Birth			
Home Phone			Work Phone				
Mailing Address: Street			State	Zip			
:t							
me: Relationship:							
	(Work)		(Cell)				
VACCINE Check appropriate box Each Immunization DOSE Was Given							
tussis	2	3	4 5				
1	2	3	,				
MR)	2	Mumps disease d	Rubella Serology/Date/Titer Mumps disease diagnosed by a physician: Date Measles Serology/Date/Titer				
	2						
1	2	3					
		required per Regulati	ions of the Departmen				
SITE: LA / RA	GIVEN BY:	ANTIGEN NAME	LOT # / EXP DATE	SIGNATURE			
	N HISTORY (R Eate box rtussis IMR) I asse s	reet Cit Relationship: (Work) N HISTORY (Recommended, but not lease l	Cell Phone reet City Relationship: (Work) N HISTORY (Recommended, but not mandated by law) E Enter Month, Day Each Immunization DC rtussis 1	Cell Phone Worl reet City State Relationship: (Work) (Cell) NHISTORY (Recommended, but not mandated by law) Enter Month, Day, and Year Each Immunization DOSE Was Given rtussis			

IGRA TEST RESULTS

Heart – Murmur, etc... Lungs – Adventious Findings

DATE COLLECTED	TEST NAME (QFT-GIT, T- SPOT, etc)	POSITIV	VE NE	GATIVE	INDETERMINATE	QUANTITATIVE RESULT
ATE TEST COMPI		SIGNATURE				
roviously known/now	positive reactors:					
icviously known/new	positive reactors.					
hest X-ray: Date:		Results: Otl (Ar		h a copy of the	Results:	
reventive Anti-Tubero	culosis Chemotherapy of	ordered: No) <u> </u>	Yes Dat	e:	_
	ACTION WAS REPOR E FROM TUBERCUL			PROVIDER RE	PORT MUST STATE	THAT THE APPLIC
V. MEDICAL CO	NDITIONS (✔)					
	Ye	s No	If Yes, Expla	ain:		
llergies						
thma	_					
rdiac		<u> </u>				
nemical Dependency						
ugs						
cohol		<u> </u>				
iabetes Mellitus		<u> </u>				
astrointestinal Disord		<u> </u>				
earing Disorder		<u> </u>				
ypertension		<u> </u>				
euromuscular Disorde	_	<u> </u>				
rthopedic Condition		<u> </u>				
espiratory Illness		<u> </u>				
eizure Disorder		H				
kin Disorderision Disorder		H				
ther (Specify)	_	H				
. PHYSICAL EX	AMINATION (*)	NORMAL	ABNORMAL	NOT EXAMINED	СО	MMENTS
Height (inches)				EM RVIII (ED		
Weight (pounds)						
Pulse						
Blood Pressure						
Hair/Scalp						
Skin						
	,					
Eyes – Visual Acuity: RI						
Eyes – Color Vision						
Ears – Hearing (dB) RL						
Nose and Throat						
Teeth and Gingiva				ļ		
Lymph Glands						

Abdomen									
Genitourinary									
Neuromuscular System									
Extremities									
Are there any special medical problems or his/her work role? If so, specify	chronic disea	ases which requi	re restriction of	f activity, medication which might affect					
Are there any special equipment or accommodations needed to enable this person to perform their duties? 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.									
i authorize the physician or other person to disclose any k	nowledge or inform	nation pertaining to m	y nealth to the emplo	bying authority for whom this examination is performed.					
Signature of Employee	Date								