Employee Physical Examination Form

Last Name:___________________ First Name:___________________ Middle Initial:_____
Address:____________________________________________________________________

Position in District:___________________________________________________________

Birth Date:____________________ Height:__________ Weight:_________ Sex:_________

1. Is there any evidence of congenital back deformity? Yes:_____ No:_______
  If yes, Please explain:___________________________________________________

2. Is there any evidence of back surgery? Yes:_____ No:_______
  If yes, Please explain:___________________________________________________

3. Is there any evidence of any surgery or accident scar tissue? Yes:_____ No:_______
  If yes, Please explain:___________________________________________________

4. Is there any evidence of birth defects? Yes:_____ No:_______
  If yes, Please explain:___________________________________________________

5. Additional findings/comments:


7. General Appearance:
   Eyes    Normal:_____ Abnormal:_____ Findings:____________
   Ears    Normal:_____ Abnormal:_____                     
   Nose    Normal:_____ Abnormal:_____                     
   Throat  Normal:_____ Abnormal:_____                     
   Neck    Normal:_____ Abnormal:_____                     
   Lungs   Normal:_____ Abnormal:_____                     
   Heart   Normal:_____ Abnormal:_____                     
   Breasts Normal:_____ Abnormal:_____                     
   Abdomen Normal:_____ Abnormal:_____                     
   Reflexes Normal:_____ Abnormal:_____                     
   Extremities Normal:_____ Abnormal:_____                 

9. *TB test/ Date Given:__________ Date Read:__________
   Result of TB test:  Negative:_______ Positive:_______ Physicians Initials:_____

10. Hepatitis B Series: [not mandatory]    Record indicates:    Record indicates: or Record indicates:
    Completed:__________ Started:_______ Declined:_______

11. Immunizations Current: Yes:_____ No:_______ Date of last DT:______________

Physicians Certification:

I hereby certify that I have examined ______________________________ and find him/her to be fit for employment in the position of which he/she has been employed and to be free from all communicable diseases.

Date of Examination:__________ Name of Physician:________________________
Address of Physician:____________________ Phone:____________________

Physician’s Signature:_________________________________________