

KENTUCKY DEPARTMENT OF EDUCATION**MEDICAL EXAMINATION OF SCHOOL EMPLOYEES***

Name _____ Date of Birth _____ Sex: M ____ F ____

Address _____ Telephone _____

Applicant With Or Employed By Dawson Springs Board of Education**HISTORY**Medical (*All serious medical and psychiatric diseases: Diabetes, Epilepsy, Heart Disease, etc.*)Surgical (*All major operations*)Family History (*T.B., Epilepsy, Diabetes, etc.*)**PHYSICAL**

- | | |
|------------------------------|-------------------------------------|
| 1. General Appearance _____ | 7. Blood Pressure _____ Pulse _____ |
| 2. Eyes _____ | 8. Lungs _____ |
| 3. Ears, Nose & Throat _____ | 9. Abdomen _____ |
| 4. Teeth and Gums _____ | 10. Nervous System _____ |
| 5. Thyroid _____ | 11. Extremities _____ |
| 6. Heart _____ | 12. Other _____ |

T.B. Skin Test

Date Given: _____

Date Read: _____

Date X-ray Taken: _____

Type of Test: _____

By Whom: _____

OR

No further follow-up
necessary unless signs
or symptoms develop

Millimeters of Induration: _____

RETURN FORM TO SUPERINTENDENT'S OFFICE**CERTIFICATION OF MEDICAL EXAMINATION**

This is to certify that I have examined _____ and find him/her free of communicable disease and any physical or mental disabilities that might interfere with performing his/her duties, except as follows:

Date of Examination

Signature (Physician/PA/ARNP)*** A separate form is provided for bus drivers**