

KENTUCKY DEPARTMENT OF EDUCATION
MEDICAL EXAMINATION OF SCHOOL EMPLOYEES*

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

Address _____ Telephone _____

Applicant With Or Employed By _____ 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 & Gums _____ | 10. Nervous System _____ |
| 5. Thyroid _____ | 11. Extremities _____ |
| 6. Heart _____ | Other _____ |

Tuberculosis Risk Factor Assessment

Yes No High risk for Tuberculosis infection

Yes No Referred to local health department for further TB infection evaluation

Yes No Tuberculosis test performed (specify: _____TST/_____BAMT)

_____ Date of chest X-Ray

No further follow-up unless signs/symptoms of Tuberculosis infection develop

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