

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

**I. INFORMATION**

School Position Offered \_\_\_\_\_

Last Name	First	MI	Sex	Date of Birth
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Home Phone	Cell Phone	Work Phone
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Mailing Address: Street	City	State	Zip
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**Emergency Contact**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number: (Home)	(Work)	(Cell)
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**II. IMMUNIZATION HISTORY** (Recommended, but not mandated by law)

VACCINE Check appropriate box	Enter Month, Day, and Year Each Immunization DOSE Was Given				
Diphtheria, Tetanus with Pertussis <input type="checkbox"/> Td <input type="checkbox"/> TdaP	1	2	3	4	5
Hepatitis B	1	2	3		
Measles-Mumps-Rubella (MMR)	1	2	Rubella Serology/Date/Titer		
			Mumps disease diagnosed by a physician: Date		
			Measles Serology/Date/Titer		
Varicella <input type="checkbox"/> Vaccine <input type="checkbox"/> Disease <input type="checkbox"/> Serology Date: Neg/Pos	1	2			
Influenza	1	2	3		

**III. TUBERCULOSIS SKIN TEST RESULTS** (Testing required per Regulations of the Department of Health)

DATE GIVEN	SITE: LA / RA	GIVEN BY:	ANTIGEN NAME	MANUFACTURER / LOT # / EXP DATE	SIGNATURE
DATE READ	RESULTS in MM		READ BY SIGNATURE		

**OR**

**IGRA TEST RESULTS**

DATE COLLECTED	TEST NAME (QFT-GIT, T-SPOT, etc)	POSITIVE	NEGATIVE	INDETERMINATE	QUANTITATIVE RESULT

DATE TEST COMPLETED \_\_\_\_\_

SIGNATURE \_\_\_\_\_

Previously known/new positive reactors: \_\_\_\_\_

Chest X-ray: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_ Other: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_  
 (Attach a copy of the report.) (Attach a copy of the report.)

Preventive Anti-Tuberculosis Chemotherapy ordered:  No  Yes Date: \_\_\_\_\_

IF SIGNIFICANT REACTION WAS REPORTED, THE PRIMARY CARE PROVIDER REPORT MUST STATE THAT THE APPLICANT IS CURRENTLY FREE FROM TUBERCULOSIS DISEASE.

**IV. MEDICAL CONDITIONS (✓)**

	Yes	No	If Yes, Explain:
Allergies .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiac .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemical Dependency .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes Mellitus .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuromuscular Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthopedic Condition.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory Illness.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (Specify).....	<input type="checkbox"/>	<input type="checkbox"/>	_____

**V. PHYSICAL EXAMINATION (✓)**

	NORMAL	ABNORMAL	NOT EXAMINED	COMMENTS
Height (inches)				
Weight (pounds)				
Pulse				
Blood Pressure				
Hair/Scalp				
Skin				
Eyes – Visual Acuity: RL				
Eyes – Color Vision				
Ears – Hearing (dB) RL				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart – Murmur, etc...				
Lungs – Adventitious Findings				

Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				

Are there any special medical problems or chronic diseases which require restriction of activity, medication which might affect his/her work role? If so, specify

Are there any special equipment or accommodations needed to enable this person to perform their duties? If so, specify

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Physician Name (Print) Signature of Examiner

Date

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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.

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Signature of Employee

Date