

KENTUCKY DEPARTMENT OF EDUCATION

MEDICAL EXAMINATION OF SCHOOL EMPLOYEES *

Name _____ Birth date _____ Sex _____

Address _____ Telephone Number _____

Applicant with or Employed by _____

Board of Education _____

HISTORY

Medical (All serious medical & psychiatric diseases: Diabetes, Epilepsy, Heart Disease, etc.)

Surgical (All major operations) _____

Traumatic History (T.B., Epilepsy, Diabetes, etc.) _____

PHYSICAL

- 1. General Appearance _____
- 2. Eyes _____
- 3. Ears, Nose & Throat _____
- 4. Teeth and Gums _____
- 5. Thyroid _____
- 6. Heart _____

- 7. Blood Pressure _____ Pulse _____
- 8. Lungs _____
- 9. Abdomen _____
- 10. Nervous System _____
- 11. Extremities _____
- 12. Other _____

TESTS

Pos. Neg.

Tuberculin or X-ray _____

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

_____, M.D.
Signature



PLEASE MAKE A COPY FOR YOUR OWN FILES