

**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 and Gums _____ | 10. Nervous System _____ |
| 5. Thyroid _____ | 11. Extremities _____ |
| 6. Heart _____ | 12. Other _____ |

Tuberculosis (T.B.) Skin Test

Date Given: _____
Type of Test: _____
Millimeters of Induration: _____

Date Read: _____
By Whom: _____

Date X-ray Taken: _____
OR

No Further follow-up necessary
Unless signs/symptoms of
Tuberculosis develop

TEAR OFF THIS PORTION AND RETURN TO SCHOOL 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.