PATERSON CHARTER SCHOOL FOR SCIENCE AND TECHNOLOGY
MEDICAL EXAMINATION FOR SCHOOL EMPLOYEES

Name ______________________ Date of Birth ____/____/____ Sex: M ☐ F ☐

Address ______________________ Telephone ______________

POSITION APPLIED FOR: ______________________

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 ______________
2. Eyes ______________
3. Ears, Nose & Throat ______________
4. Teeth & Gums ______________
5. Thyroid ______________
6. Heart ______________
7. Blood Pressure __________ Pulse __________
8. Lungs ______________
9. Abdomen ______________
10. Nervous System ______________
11. Extremities ______________

Other ______________

____

TUBERCULOSIS – TB SKIN TEST IS REQUIRED FOR EMPLOYMENT

Date of Test ______________

Location ______________

Reading Date ______________

Test Result _____Negative

_____mm Positive (*ALL positive tests must have a Chest X-ray)

Tb skin test is required regardless of having received the BCG vaccine according to CDC.

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)

PATERSON CHARTER SCHOOL
FOR SCIENCE AND TECHNOLOGY
276 Wabash Avenue
Paterson, New Jersey 07053

SCHOOL HEALTH OFFICE

STAFF HEALTH HISTORY

NAME:____
Last First MI

ADDRESS:____

____

PHONE: ______________________

NEW EMPLOYEE:________ RETURNING EMPLOYEE:________

POSITION:________________________

PERSON TO BE NOTIFIED IN CASE OF AN EMERGENCY:

NAME:_________________________ TEL. #________________

HEALTH HISTORY

DO YOU HAVE ANY HISTORY OF: (PLEASE CIRCLE ONE)

ASTHMA	YES	NO	KIDNEY DISEASE	YES	NO
DIABETES	YES	NO	RHEUMATIC FEVER	YES	NO
HEART CONDITION	YES	NO	FAINTING SPELLS	YES	NO
HIGH BLOOD PRESSURE	YES	NO	CONVULSIVE DISORDER	YES	NO

DATE OF LAST TB TEST:___________ WAS THE RESULT POSITIVE? YES NO
IF THE RESULT WAS POSITIVE, DID YOU HAVE A CHEST X-RAY & WHEN?__________

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS OR FOOD? YES NO
IF YES, PLEASE INDICATE WHICH:______________________________________

PLEASE LIST ANY MEDICATIONS PRESENTLY PRESCRIBED TO YOU THAT WOULD BE IMPORTANT TO KNOW IN CASE OF AN EMERGENCY:

____

PLEASE LIST ANY HEALTH PROBLEMS YOU FEEL WOULD BE IMPORTANT TO KNOW IN CASE OF AN EMERGENCY:

____

SIGNATURE:_________________________________ DATE:_______________