DEPARTMENT OF EDUCATION
HUMAN RESOURCES DIVISION

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Superintendent of Education

KATHERINE M.P. ADA
Personnel Services Administrator

Report of Medical Examination

IMPORTANT: This report of Medical Examination must be completed and submitted within 60 days of your effective date of hire.

Issue Date: _____ Due Date: _____

Date of Examination: _____

1. Name (Last, First & Middle Initial):		**2. Current Position Title:**
3. Residential Address:		**4. Sex: [ ] Male [ ] Female**
5. Race:	**6. Date of Birth:**	**7. Place of Birth:**
8. Next of Kin (Please indicate Name & Relationship):		
9. Next of Kin's Address:		

ALL ITEMS BELOW ARE TO BE COMPLETED BY PHYSICIAN ONLY

10. Height	**11. Weight**	**12. Hair Color**	**13. Eye Color**	**14. Build**
				[ ] Slender [ ] Medium [ ] Heavy [ ] Obese

15. Hearing:	**16. Vision:**	**17. Temperature:**
RT WV/155 v/15 **LT WV/155 v/15**	**RT 20/Correct to 20/20:** **LT 20/Correct to 20/20:**	

18. Respiration:	**19. Blood Pressure: (Arm at Heart Level)**			**20. Pulse: (Heart Low)**	
	Sitting	**Sys Dias**	**Recumbent**	**2 Minutes After Exercise – Standing**	**2 Minutes After Exercise – Sitting**

21. Clinician Evaluation: Please check appropriate box and describe any abnormality as applicable.

Area of Examination	Normal	Abnormal	Not Examined	Description of Abnormality
Head, Face, Neck & Scalp				
Nose, Mouth, Throat				
Sinuses				
Ears – General (Internal & External Canal) (Acoustic Acuity -Item 15)				
Drums (Perforation)				
Eyes – General (Visual Acuity - Item 16)				
Opthalmoscopic Exam				
Pupils (Equality & Reaction)				
Ocular Movement				
Lungs & Chest				
Breast				

Name (Please Print): _____

Area of Examination	Normal	Abnormal	Not Examined	Description of Abnormality
Heart				
Vascular System				
Abdomen				
Anus, Rectum				
Endocrine				
G-U System				
Upper Extremities				
Lower Extremities				
Feet				
Spine & Other Musculoskeletal				
Identifiable Body Marks, Scars, Tattoos				
Skin / Lymphatic				
Pelvic / Pap (Females Only)				
Prostate (Males Only)				

22. Laboratory Findings

CBC (No Differential) **Date:**	**Fasting Blood Sugar** **Date:**	**Urinalysis** **Date:**	**Hemo-cult** **Date:**
Hepatitis Screening **Date:**	**Cholesterol** **Date:**	**Chest X-Ray** **Date:**	**Other Test:** **Date:**

Remarks: Clinical Evaluation Comments, Recommendations, Summary of Mental or Physical Defects & Diagnosis: (Use additional sheets of plain paper if necessary)

Based on the result of the examination, the examinee: Examinee

[ ] Does meet [ ] Does Not meet _____ **health and physical condition standard deemed necessary and proper for the performance of the duties and responsibilities of position indicated under Item number 2.**

(indicate appropriate box)

Print Name of Examining Physician:

Signature of Examining Physician: **Date:**

Address of Examining Physician (Number, Street, and Village or RFD City, State)