# HEALTH EXAMINATION CERTIFICATE

**North Carolina Public Schools**

Required of all persons upon initial employment, separation from employment more than one school year, absence of more than 40 successive days because of a communicable disease, or when deemed necessary by a local school board or superintendent. (Ref. NCGS 115C-323)

Name: _____ Social Security Number: _____

Address: _____

_____

The above named individual is to be recommended for employment by _____ (local school board) for the position of _____. In this position, the condition of certain physical capacities will be of importance. Please examine the areas listed below and report any limitations, deficiencies or related restrictions.

## I. Communicable Diseases

By my signature I certify that the above named person does not have any communicable disease, including tuberculosis, that poses a significant risk of transmission in our schools or would impair this person's ability to perform the duties of the job, except as may be noted below. Further, I certify that this person is free of any physical or mental disability that would impair job performance.

If unable to certify the above, please comment:

**TB Skin Test Results**

Date Placed:_____ Results:_____mm_____

Signature_____

_____

_____

## II. Other Health Areas

| AREAS | LIMITATIONS YES | NO | NATURE OF LIMITATIONS (continue on back as needed) |
|---|---|---|---|
| Vision | | | |
| Hearing | | | |
| Heart | | | |
| Lungs | | | |
| Lifting/Carrying | | | |

| Appropriate Immunizations | Current? YES | NO | Any Immunization Recommendations |
|---|---|---|---|
| Td (tetanus) Hep. B. MMR. etc. | | | |

Date: _____

_____
Physician, Physician's Assistant, or Nurse Practitioner (Type or Print)

SIGNATURE:_____

License/Registration #: _____ State* Granting License/Registration:_____

*For initial employment of an out-of-state applicant the certificate may be completed by a health care provider with an out-of-state unrestricted current license or registration.

1/2002

**EMPLOYEE/ISS**

**THIS FORM MUST BE COMPLETED BY A PHYSICIAN.**

January 2014
North Carolina Tuberculosis Control Program

## Tuberculosis Risk Questionnaire

| | | |
|---|---|---|
| 1) Were you born outside the USA in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe? | YES | NO |
| 2) Have you traveled outside the USA and lived for more than one month in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe? | YES | NO |
| 3) Do you have a compromised immune system such as from any of the following conditions: HIV/AIDS, organ or bone marrow transplantation, diabetes, immunosuppressive medicines (e.g. prednisone, Remicade), leukemia, lymphoma, cancer of the head or neck, gastrectomy or jejeunal bypass, end-stage renal disease (on dialysis), or silicosis? | YES | NO |
| 4) Have you ever done one of the following: used crack cocaine, injected illegal drugs, worked or resided in jail or prison, worked or resided at a homeless shelter, or worked as a healthcare worker in direct contact with patients? | YES | NO |
| 5) Have you ever been exposed to anyone with infectious tuberculosis? | YES | NO |

## Tuberculosis Symptom Questionnaire

Do you currently have any of the following symptoms?

| | | |
|---|---|---|
| 1) Unexplained cough lasting more than 3 weeks | YES | NO |
| 2) Unexplained fever lasting more than 3 weeks | YES | NO |
| 3) Night sweats (sweating that leaves the bedclothes and sheets wet) | YES | NO |
| 4) Shortness of breath | YES | NO |
| 5) Chest pain | YES | NO |
| 6) Unintentional weight loss | YES | NO |
| 7) Unexplained fatigue (very tired for no reason) | YES | NO |

PHYSICIAN'S SIGNATURE _____ DATE _____