2018-2019 SUMMER IN-SERVICE

JULY 17, 2018

8:00 a.m.

AMITE HIGH SCHOOL AUDITORIUM

JULY 18, 2018

8:00 a.m.

PONCHATOULA HIGH SCHOOL AUDITORIUM

INFORMATION UPDATE
2018-2019 SCHOOL YEAR

Please check one

☐ Substitute Bus Driver

☐ Bus Attendant

☐ Activity Driver

☐ Substitute Bus Attendant

Name: _____

Mailing Address: _____

_____

Physical Address: _____

_____

Home Phone: _____

Cell Phone: _____

Emergency Phone: _____

E-Mail Address: _____

****

ACTIVITY DRIVERS:

ASSIGNED SCHOOL: _____

August				
M	T	W	TH	F
		1	2	3
6	7	8	***9***	10
13	14	15	16	17
20	21	22	23	24
27	28	29	30	31

September				
M	T	W	TH	F
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24	25	26	27	28

October				
M	T	W	TH	F
1	2	3	4	5
8	9	10	11	12
15	16	17	18	19
22	23	24	25	26
29	30	31		

November				
M	T	W	TH	F
			1	2
5	6	7	8	9
12	13	14	15	16
19	20	21	22	23
26	27	28	29	30

December				
M	T	W	TH	F
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24	25	26	27	28
31				

September

3rd-Labor Day Holiday (No School)

14th-August Pre-Trip Report

14TH -Mileage Passenger List & Rolling Route

October

5th-Fair Day (No School)

15th-September Pre-Trip Report

November

15th -October Pre-Trip Report

19th-23rd-Thanksgiving Holiday (No School)

December

14th-November Pre-Trip Report

12/21st-1/4th -Christmas Holiday

January

1st – 4th – New Year Holidays

7th – Professional Development (No Students)

8th – Students Return

15th-December Pre-Trip Report

21st – MLK Holiday (No School)

February

15th-January Pre-Trip Report

28th-Semi-Annual Inspection

March

4th-6th Mardi Gras

15th-February Pre-Trip Report

18th Teacher PD Day (No School)

April

15th-March Pre-Trip Report

19th-26th-Easter Holiday (No School)

29th-Students Return

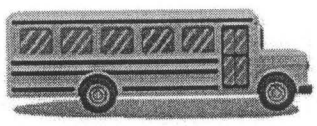
May

15th- April Pre-Trip Report

22nd-Last Day for Students

June

14th-May Pre-trip Report



February				
M	T	W	TH	F
				1
4	5	6	7	8
11	12	13	14	15
18	19	20	21	22
25	26	27	28	

March				
M	T	W	TH	F
				1
4	5	6	7	8
11	12	13	14	15
18	19	20	21	22
25	26	27	28	29

April				
M	T	W	TH	F
1	2	3	4	5
8	9	10	11	12
15	16	17	18	19
22	23	24	25	***26***
29	30			

May				
M	T	W	TH	F
		1	2	3
6	7	8	9	10
13	14	15	16	17
20	21	***22***	23	24
27	28	29	30	31

June				
M	T	W	TH	F
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24	25	26	27	28

NORTHOAKS
OCCUPATIONAL HEALTH SERVICES

Tangipahoa Parish School System
Transportation Department
59656 Puleston Road
Amite, Louisiana 70422

Name (print): _____ Social Security #: _____

REVIEW OF SYMPTOMS

1. DO YOU HAVE, OR HAVE YOU EVER HAD: Check "Y" for Yes or "N" for No.

Please check all that apply and use the comment section at the bottom of the page for any explanation.

Y	N	
☐	☐	Night Sweats
☐	☐	Recent Weight Loss/Gain
☐	☐	Convulsions or Fits
☐	☐	Memory Loss
☐	☐	Numbness/Tingling
☐	☐	Fainting/Dizzy Spells
☐	☐	Headaches
☐	☐	Paralysis
☐	☐	Stroke/Blood Clot
☐	☐	Wear Glasses (check below)
		☐ Reading
		☐ Distance
		☐ Contact Lenses
☐	☐	Color Blindness
☐	☐	Cataracts
☐	☐	Glaucoma
☐	☐	Vision Problems
☐	☐	Hearing Problems
☐	☐	Noise in Ears
☐	☐	Balance Problems
☐	☐	Sinus Problems
☐	☐	Mouth Sores
☐	☐	Change in Voice
☐	☐	Hoarseness
☐	☐	Difficulty Swallowing
☐	☐	Skin Diseases
☐	☐	Cancer

Y	N	
☐	☐	Heart Problems
☐	☐	Chest Pain
☐	☐	Rheumatic Fever
☐	☐	Irregular Heart Beat
☐	☐	Heart Murmur
☐	☐	High Blood Pressure
☐	☐	Swollen Ankles
☐	☐	Varicose Veins
☐	☐	Shortness of Breath
☐	☐	Ulcers
☐	☐	Change in Bowel or Bladder Habits
☐	☐	Hernia
☐	☐	Nausea/Vomiting
☐	☐	Blood in Urine
☐	☐	Kidney Problems
☐	☐	Reproductive Problems
☐	☐	Bladder Infections
☐	☐	Back Injury
☐	☐	Joint Injury/Pain
☐	☐	Arthritis
☐	☐	Broken Bones
☐	☐	Blood Disease
☐	☐	Bleed Easily
☐	☐	Anemia
☐	☐	Diabetes

Y	N	
☐	☐	Alcohol Use (check below):
		☐ Beer
		☐ Wine
		☐ Liquor
☐	☐	Trouble Sleeping
☐	☐	Stress
☐	☐	Depression
☐	☐	Prior Drug/Alcohol Treatment
☐	☐	Any Lung Trouble
☐	☐	Hay Fever
☐	☐	Asthma
☐	☐	Bronchitis
☐	☐	Pneumonia
☐	☐	Tuberculosis
☐	☐	Persistent Cough
☐	☐	Cough up Blood
☐	☐	Tobacco Use (check all that apply):
		_____ # of years
		☐ Cigarettes ____ packs/day
		☐ Cigars ____ day
		☐ Pipe ____ bowls/day
		☐ Chew Tobacco/Snuff
		☐ Still Smoking
		☐ Quit Date _____
		☐ Second Hand Smoke Exposure
		_____Work _____ Home
☐	☐	Change in any Wart or Mole
☐	☐	Thyroid Problems

Comments: _____

_____

_____

Applicant/Employee: I certify that the above information is true and correct to the best of my knowledge.

Signature: _____ Date: _____/_____/_____

FOR OFFICE USE ONLY

Reviewed by: _____
Signature Print Name & Title Date

NORTHOAKS
OCCUPATIONAL HEALTH SERVICES

Name (print): _____ Social Security #: _____

3. **Do you use any prosthesis, colostomy appliances, artificial limbs, braces, assistive devices (glasses, hearing aids)?**
☐ No ☐ Yes If "Yes", please explain. _____

4. **Do you have any hobbies?**
☐ No ☐ Yes If "Yes", please explain hobbies, substances used (glue, paint, chemicals, etc.) and physical exposure (noise, temperature extremes, etc.). _____

5. **Please list medications, prescribed or over the counter, and health food supplements.**

_____

_____

_____

6. **Allergy/Immune Status**

Please check if you have allergies to the following:

	NO	YES
Medications	☐	☐
Latex	☐	☐
Food	☐	☐
Powder	☐	☐
Other	☐	☐

List any medication allergies: _____

List any food allergies: _____

List any other allergies: _____

Do you have a history of:

NO	YES	UNKNOWN	
☐	☐	☐	Hepatitis A
☐	☐	☐	Hepatitis B
☐	☐	☐	Hepatitis C
☐	☐	☐	Body Piercing
☐	☐	☐	Tattoos
☐	☐	☐	Have you had an accidental needle stick and/or blood and body fluid exposure in the past? If "Yes", please give the date: ____/____/_____

Last Blood Donation Date: ____/____/_____

7. Emergency Contact Information:

Name: _____
Relationship: _____
Number: _____

Name: _____
Relationship: _____
Number: _____

Childhood Diseases (Please check if you have had):

☐ Red Measles
☐ Mumps
☐ Rubella
☐ Chickenpox
☐ Polio

TB Skin Test:
Date: ____/____/_____
Result: _____

OCCUPATIONAL HISTORY

8. **Work History** – In chronological order, list each job, including military service.

FROM	TO	POSITION/JOB DUTIES	COMPANY
____/____/_____	____/____/_____	_____	_____
____/____/_____	____/____/_____	_____	_____
____/____/_____	____/____/_____	_____	_____
____/____/_____	____/____/_____	_____	_____

Applicant/Employee: I certify that the above information is true and correct to the best of my knowledge.

Signature: _____ Date: ____/____/_____

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Signature Print Name & Title Date

NORTHOAKS
OCCUPATIONAL HEALTH SERVICES

Name (print): _____ Social Security #: _____

OCCUPATIONAL HISTORY

9. Please check all that apply: Check "Y" for Yes or "N" for No

A. Have you ever worked in or around the following:

Y	N		Y	N		Y	N	
☐	☐	Chemical Plant	☐	☐	Foundry	☐	☐	Other job sites with hazardous exposures (list below.)
☐	☐	Construction Site	☐	☐	Mine			_____
☐	☐	Cotton, Flax or Hemp Mill	☐	☐	Outdoor Areas			_____
☐	☐	Electronics Plant	☐	☐	Paper/Lumber Mill			_____
☐	☐	Farm	☐	☐	Refinery			
☐	☐	Fiber Mill	☐	☐	Shipyard			
			☐	☐	Dusty Jobs			

B. Have you ever used or been exposed to the following chemicals or conditions:

Y	N		Y	N		Y	N	
☐	☐	Arsenic	☐	☐	Lead	☐	☐	Repetitive Motion/Vibration
☐	☐	Asbestos	☐	☐	Loud Noises	☐	☐	Solvents/Degreasers
☐	☐	Benzene	☐	☐	Mercury/Other Heavy Metal	☐	☐	Spray Painting
☐	☐	Beryllium	☐	☐	Lasers	☐	☐	Trichloroethylene
☐	☐	Cadmium	☐	☐	Pesticides	☐	☐	Welding/Soldering
☐	☐	Carbon Tetrachloride	☐	☐	Phenols	☐	☐	Other (list below)
☐	☐	Changes in Temperature	☐	☐	Phosgene			_____
☐	☐	Chromates	☐	☐	Plastics			_____
☐	☐	Dust	☐	☐	PVC's			_____
☐	☐	Fluoride	☐	☐	Radioactive Materials			

C. Do you have (or have you ever had) any hobbies/recreational activities that include:

Y	N		Other: *(list below)*
☐	☐	Loud Noises (shooting, cycling)	_____
☐	☐	Weight Lifting (to _____ pounds)	_____
☐	☐	Paints/Solvents/Glues	_____

D. Have you recently used personal protective equipment on your prior jobs?

Y	N		Other: *(list below)*
☐	☐	Respirator	_____
☐	☐	Hearing Protectors	_____
☐	☐	Gloves	_____
☐	☐	Protective Clothing	
☐	☐	Safety Glasses/Goggles	

E. Have you ever received medical surveillance (periodic check-ups or tests) as part of a prior job?
☐ No ☐ Yes If "Yes", please explain. _____

F. Do you have any environmental allergies?
☐ No ☐ Yes If "Yes", please explain. _____

G. Do you have any history of insect or tick bites?
☐ No ☐ Yes If "Yes", please explain. _____

Applicant/Employee: I certify that the above information is true and correct to the best of my knowledge.

Signature: _____ Date: ____/____/____

FOR OFFICE USE ONLY

Reviewed by: _____
Signature Print Name & Title Date

NORTHOAKS
OCCUPATIONAL HEALTH SERVICES

Name (print): _____ Social Security #: _____

EMPLOYEE PHYSICAL

1. Has a physician ever restricted your activities? ☐ No ☐ Yes
   If "Yes", please list the medical condition, what type of restrictions were placed, whether these restrictions were temporary or permanent, and whether you are presently under these restrictions.

   _____

   _____

2. Are you currently under any medical treatment by a physician, psychiatrist, psychologist or other physician? ☐ No ☐ Yes
   If "Yes", please list the medical condition being treated and your treating physician's name.

   _____

   _____

3. Date of last Physical Exam _____/_____/_____

4. Have you ever had surgery on any part of your body? ☐ No ☐ Yes
   If "Yes", please list the type of operation and your physician's name.

   _____

   _____

   _____

5. Have you ever received treatment for your back, neck, knee or other body part from a physician, chiropractor or therapist?
   ☐ No ☐ Yes
   If "Yes", please list the name of the physicians, chiropractors or therapists who performed the treatment.

   _____

   _____

   _____

6. Have you ever had an injury which required you to miss work? ☐ No ☐ Yes
   If "Yes", please list the type of injury, the amount of time missed from work, whether the condition fully healed or if it left you with any impairment, and whether you returned to work.

   _____

   _____

   _____

WARNING: **Failure to truthfully answer inquiries about previous medical conditions may result in my forfeiture of Workers' Compensation benefits under R.S. 23:1208.1.**

I have read and fully understand the above.

Signature: _____ Date: _____/_____/_____

FOR OFFICE USE ONLY

Reviewed by: _____
Signature Print Name & Title Date

NORTHOAKS
OCCUPATIONAL HEALTH SERVICES

Name (print): _____ Social Security #: _____

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PHYSICAL EXAMINATION

Complaints: _____

PMH: _____ PSH: _____ OB/GYN: _____

Physical Examination

Blood Pressure: _____/_____ Pulse: _____
Resp.: _____ Temp: _____
Height: _____ Weight: _____ lbs.

Ancillary Tests (select according to exam)

_____
_____
_____

Vision ☐ Uncorrected ☐ Corrected

	Right	Left	Both
Near	20/	20/	20/
For	20/	20/	20/

Ishihara's Test _____/14 correct
Visual Fields Right_____ Left_____

Does patient wear eyeglasses? ☐ Yes ☐ No
Does patient wear contact lenses? ☐ Yes ☐ No
Is patient wearing glasses/contacts? ☐ Yes ☐ No

Other Tests:

_____
_____
_____

Check if Normal/Circle if Abnormal

1. Head/Neck
☐ Head/Neck ☐ Hearing
☐ Ear ☐ Eye ☐ Nose ☐ Throat ☐ Oral Cavity

2. Heart/Lungs
☐ Peripheral pulse
☐ Heart sounds ☐ Lungs

3. Gastrointestinal
☐ Abdomen

4. Genitourinary
☐ Genitals ☐ Pelvis(female)/N.I. ☐ Prostate/N.I.

5. Skin & Soft Tissue
☐ Lymph nodes ☐ Breasts (male/female)/N.I.
☐ Skin (attach drawing of burns, scars, etc)

6. Musculoskeletal
☐ Limbs/joints ☐ Spine/Back

7. Neurological
☐ Mental Status
☐ Balance ☐ Gait ☐ Coordination
☐ Reflexes

Comments: _____
_____

Employee/Applicant medically qualified to wear:
Respirator: ☐ Yes ☐ No ☐ NA

Based on information obtained from the history of this patient, this individual IS / IS NOT free of communicable disease at this time.

Based on findings of this physical examination: Employee/Applicant IS / IS NOT physically qualified (pending results of any outstanding ancillary tests) for employment at: _____.

Impression: _____

Recommendations: _____

Signature of Examiner: _____ Date: _____/_____/_____

Print Name: _____ Title: _____