

**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) \_\_\_\_\_

*"Per the Genetic Information Nondiscrimination Act of 2008, it is unlawful for an employer to request genetic information, genetic testing information, family medical history information, or family genetic testing information from an applicant or employee. The medical provider conducting this examination of an applicant/employee of a local school district shall not request, require or purchase this information about the applicant or employee. Any applicant or employee undergoing a medical examination for employment with a local school district shall not provide this information to the medical provider or the school district."*

**PHYSICAL**

- |                              |                                     |
|------------------------------|-------------------------------------|
| 1. General Appearance _____  | 7. Blood Pressure _____ Pulse _____ |
| 2. Eyes _____                | 8. Lungs _____                      |
| 3. Ears, Nose & Throat _____ | 9. Abdomen _____                    |
| 4. Teeth & Gums _____        | 10. Nervous System _____            |
| 5. Thyroid _____             | 11. Extremities _____               |
| 6. Heart _____               | Other _____                         |

**Tuberculosis Risk Factor Assessment**

Yes  No  High risk for Tuberculosis infection

Yes  No  Referred to local health department for further TB infection evaluation

Yes  No  Tuberculosis test performed (specify: \_\_\_\_\_ TST/\_\_\_\_\_ BAMT)

\_\_\_\_\_ Date of chest X-Ray

No further follow-up unless signs/symptoms of Tuberculosis infection develop

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)

\* School Bus Drivers are required to use form TC94-35E.