CENTRAL ISLIP PUBLIC SCHOOLS
Employee Health Examination Record (Completed by Employee)

NOTE: All new employees must present their physical and PPD (Mantoux) or chest x-ray prior to employment.
Teaching and non-teaching personnel may be required to have a complete physical at the request of the principal.
Cafeteria employees must have an annual physical and PPD (Mantoux).

Position: _____ School: _____
Print name: _____ Date of birth: ____/____/____
Home address: _____ Phone: _____
Street Town Zip

Notify in case of emergency: Name _____ Phone _____
Address _____ Relationship _____
Family Physician: _____ Address: _____ Phone _____

Past Personal History:

1. Have you ever been rejected from employment because of health? Yes □ No □ If yes, why? _____
2. Do you have any disabilities? Yes □ No □ If yes, indicate reason _____
3. Have you ever filed for compensation or receive any disability pension? Yes □ No □
   If yes, indicate reason _____
4. How much time have you missed from work in the last three years because of health reasons? _____
5. Do you use medication regularly? Yes □ No □
   Type: Reason:
   _____ _____
   _____ _____
   _____ _____
6. Have you had any operations, fractures or other injuries? Yes □ No □
   If yes, please give date and type: _____
7. Do you currently have any diseases or illnesses? Yes □ No □
   If yes, what? _____

APPLICANT: Have you ever had any of the following? (please check)

Condition	No	Yes	Dates/Comments	Condition	No	Yes	Date/Comments
Arthritis				Hepatitis A/Hepatitis B			
Asthma/Allergies				Hernia			
Back condition				Jaundice			
Convulsion Disorder				Psychiatric care			
Diabetes				Sinus trouble			
Failing Spells				Skin condition (type)			
Heart trouble i.e., hypertension				Tuberculosis (pos PPD)			
GI problems i.e., ulcers, colitis				Other			

HEALTH SCREENING
(To be completed by your physician)

Patient's name: _____

Allergies: _____ Height _____ Weight _____ Pulse _____ Resp. _____

_____ BP: R _____/_____ L _____/_____

PPD (Mantoux) Date Planted: _____ Vision (w/o glasses) R 20/_____ L 20/_____ Both 20/_____

Date Read/Results: _____ Vision (with glasses) R 20/_____ L 20/_____ Both 20/_____

Chest x-ray: _____ Hearing (audiogram) R _____ L _____

Urine: Sugar _____ Albumin _____

	Satisfactory Yes	Satisfactory No	Physical Evaluation/Comments	Recommend Follow-Up
General Appearance				
Glands				
Head				
Eyes				
Mouth, Pharnyx, Nose				
Ears				
Chest/Lungs				
Heart				
Abdomen				
Skin				
Bones, Joints, Muscles				
Neuro System				

Comments:

Work Restrictions Yes □ No □

Limitations Yes □ No □

The above-named person is physically fit to perform his/her duties.

_____ _____

Physician's Signature **Date**

(Physician's stamp is required)