

**PARK RIDGE PUBLIC SCHOOLS**  
**85 Pascack Road, Park Ridge, NJ 07656**  
**Tel – 201-573-6000 ext 1101 Fax – 201-391-6511**

**Employee Physical Examination Form**

**This page to be completed by staff member:**

<b>Name</b>		<b>Tel No</b>		<b>DOB</b>	
<b>Address</b>		<b>City</b>		<b>State</b>	<b>Zip</b>
<b>Position Applied for</b>				<b>PR School</b>	

History of:

Yes	No	
		1. Serious Illness
		2. Surgery
		3. Accidents or Injuries
		4. Smoking
		5. Excessive use of alcohol or drugs
		6. Allergies (medications, hay fever, asthma)
		7. Currently taking any medications
		8. Weight change in past year
		9. Headaches, difficulty seeing or hearing
		10. Chest pain, cough, shortness of breath
		11. Heart trouble or high blood pressure
		12. Rheumatic fever or scarlet fever
		13. TB, bronchitis, pneumonia or emphysema
		14. Ulcers, gall bladder trouble or liver disease
		15. Chronic indigestion or change in bowel habit
		16. Blood in urine or stool
		17. Bladder, kidney or urinary tract disease
		18. Arthritis or anemia
		19. Psychiatric or nervous disorder

If answer to any above is yes, explain: \_\_\_\_\_

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Please note: All employees are encouraged to have a yearly physical exam by their personal physician.

Date: \_\_\_\_\_

Signature of Staff Member: \_\_\_\_\_

# PARK RIDGE PUBLIC SCHOOLS

## Employee Physical Examination Form (cont.)

**This Section to be completed by staff member:**

Date: \_\_\_\_\_

Name		Tel No		DOB	
Address		City		State	Zip
Position Applied for				PR School	

**This Section to be completed by Examining Physician:**

Height			Weight		
Blood Pressure			Pulse		
Vision	R	L	Hearing	R	L
Eyes			Ears		
Nose			Throat		
Thyroid					
Lungs					
Abdomen					
Hernia					
Neuro:	Sensory		Motor		
	Tendon Reflexes		Romberg		
Laboratory	Urine:		Glucose		Protein
	Hgb/Hct:				
	Chest X-Ray (if necessary)				
	Cardiogram (if necessary)				

Mantoux test performed		Date	
Mantoux test results		Date	

Do you recommend applicant as physically fit for position indicated?

Yes \_\_\_\_\_ No \_\_\_\_\_

**COMPLETE ONLY A PHYSICAL EXAMINATION IN  
ACCORDANCE WITH YOUR CONTRACTED FEE WITH  
THE PARK RIDGE SCHOOL DISTRICT**

*Physician's Stamp*

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date