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.)* ________________

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Surgical *(All major operations* ____

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Family History *(T.B., Epilepsy, Diabetes, etc.)* ____

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PHYSICAL

1. General Appearance ____________________
2. Eyes __________________________________
3. Ears, Nose & Throat ____________________
4. Teeth and Gums _______________________
5. Thyroid ________________________________
6. Heart _________________________________
7. Blood Pressure____________ Pulse ________________
8. Lungs ____
9. Abdomen____
10. Nervous System _________________________________
11. Extremities ____________________________________
12. Other ____

T.B. Skin Test

Date Given: _____________________

Type of Test: ____________________

Millimeters of Induration: __________

Date Read: _______________

By Whom: ________________

Date X-ray Taken: ___________

OR

☐ No further follow-up necessary unless signs/symptoms of tuberculosis develop

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TEAR OFF THIS PORTION AND RETURN TO SCHOOL SUPERINTENDENT'S OFFICE

CERTIFICATION OF MEDICAL EXAMINATION

This is to certify that 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)*

*A separate form is provided for bus drivers.