



ENGLEWOOD PUBLIC SCHOOLS

DWIGHT MORROW HS, 274 KNICKERBOCKER ROAD, ENGLEWOOD, NJ 07631

EMPLOYEE HEALTH APPRAISAL/DEMOGRAPHIC SHEET

EMPLOYEE: Please complete the top portion of this **confidential** form before visiting your physician. After the physical examination, return the completed form to the Human Resources Department.

Name:	Telephone #:
Address:	Position:
City, State, Zip:	Date of Birth:

SECTION I:

- Employment Requirement:** According to New Jersey Statutes (N.J.S.A. 18A:16-2), a Mantoux intradermal tuberculin test is required to be given to all newly hired employees. An employee with a documented Mantoux test administered within the previous six months does not have to be retested. An employee transferring between school districts within New Jersey does not have to be tuberculin tested if a documented record of the test is provided upon his/her initial employment in a New Jersey public school. (See #5 in Section II)
- Record of immunizations and dates:**
Measles _____ Tetanus _____ Rubella _____ Other _____
- Please list any past serious illness and/or injury (including on-the-job injuries).** List most recent first and indicate year(s). _____
Have you lost any work time as a result of an on-the-job injury? Yes No
- List any current health problems, including allergies.** _____
- OPTIONAL:** List medications/allergies which may be of value in an emergency situation. _____

I certify that the above statements are true and correct to the best of my knowledge. The medical information provided on this health appraisal may be shared with the building principal and/or nurse.

Employee Signature _____

Date _____

SECTION II: HEALTH SCREENING / MEDICAL EVALUATION (To Be Completed By Physician)

Height:	Weight:	Blood Pressure:
Pulse:	Vision:	Hearing:
Mantoux Test		
Date Read: _____	Result: ___ Negative ___ Positive	Induration _____ mm
(If Result Is Positive)		
Date of X-Ray: _____	Result: _____	INH Preventive Therapy: ___ y ___ n

- Pertinent findings from history and physical examination:

- Does the employee/applicant require any adaptations or accommodations to perform job responsibilities?

Physician Name:	Telephone #:
Address:	Position:

Physician Signature:

Date:

The information below is requested to comply with the U.S. Equal Employment Opportunity Commission (EEOC), the Office for Civil Rights of the Department of Education, and New Jersey Affirmative Action Programs.

This data is used for statistical purposes only.

Check One: Gender

Male Female

Check One: Race

- White
 Hispanic
 Native Indian/Alaskan Native
 African American
 Asian or Pacific Islander
 Other (specify) _____

Check if applicable:

Are you a person with disabilities?