ENGLEWOOD PUBLIC SCHOOLS

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

EMPLOYEE HEALTH APPRAISAL

***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:

1. **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)
2. **Record of immunizations and dates**:
   Measles_____ Tetanus_____ Rubella_____ Other_____
3. **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
4. **List any current health problems, including allergies**. _____

   _____
5. ***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**

6. Pertinent findings from history and physical examination:

   _____

   _____
7. Does the employee/applicant require any adaptations or accommodations to perform job responsibilities?

   _____

Physician Name:	**Telephone #:**
Address:	**Position:**
Physician Signature:	**Date:**