

**SCHOOL PERSONNEL HEALTH RECORD**  
**(FOR USE AFTER OFFER OF EMPLOYMENT HAS BEEN MADE)**

**I. INFORMATION**

School Position Offered \_\_\_\_\_

|                         |       |            |       |               |
|-------------------------|-------|------------|-------|---------------|
| Last Name               | First | MI         | Sex   | Date of Birth |
| Home Phone              |       | Cell Phone |       | Work Phone    |
| Mailing Address: Street |       | City       | State | Zip           |

**Emergency Contact**

|                             |               |        |
|-----------------------------|---------------|--------|
| Name:                       | Relationship: |        |
| Address:                    |               |        |
| Telephone number:<br>(Home) | (Work)        | (Cell) |

**II. IMMUNIZATION HISTORY** (Recommended, but not mandated by law)

| VACCINE<br>Check appropriate box                        | Enter Month, Day, and Year<br>Each Immunization DOSE Was Given |   |  |   |   |
|---|--|---|--|---|---|
| Diphtheria, Tetanus with Pertussis<br>☐ Td ☐ TdaP       | 1  | 2 | 3  | 4 | 5 |
| Hepatitis B   | 1  | 2 | 3  |   |   |
| Measles-Mumps-Rubella (MMR)                             | 1  | 2 | Rubella Serology/Date/Titer<br>Mumps disease diagnosed by a physician: Date<br>Measles Serology/Date/Titer |   |   |
| Varicella☐ Vaccine☐ Disease<br>☐ Serology Date: Neg/Pos | 1  | 2 |  |   |   |
| Influenza   | 1  | 2 | 3  |   |   |

**III. TUBERCULOSIS SKIN TEST RESULTS** (Testing required per Regulations of the Department of Health)

| DATE GIVEN | SITE:<br>LA / RA | GIVEN BY: | ANTIGEN NAME      | MANUFACTURER /<br>LOT # / EXP DATE | SIGNATURE |
|------------|------------------|-----------|-------------------|------------------------------------|-----------|
|            |                  |           |                   |                                    |           |
| DATE READ  | RESULTS in MM    |           | READ BY SIGNATURE |                                    |           |
|            |                  |           |                   |                                    |           |

**OR**

**IGRA TEST RESULTS**

| DATE COLLECTED | TEST NAME (QFT-GIT, T-SPOT, etc) | POSITIVE | NEGATIVE | INDETERMINATE | QUANTITATIVE RESULT |
|----------------|----------------------------------|----------|----------|---------------|---------------------|
|                |                                  |          |          |               |                     |

DATE TEST COMPLETED \_\_\_\_\_

SIGNATURE \_\_\_\_\_

Previously known/new positive reactors: \_\_\_\_\_

Chest X-ray: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_ Other: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_  
 (Attach a copy of the report.) (Attach a copy of the report.)

Preventive Anti-Tuberculosis Chemotherapy ordered:  No  Yes Date: \_\_\_\_\_

IF SIGNIFICANT REACTION WAS REPORTED, THE PRIMARY CARE PROVIDER REPORT MUST STATE THAT THE APPLICANT IS CURRENTLY FREE FROM TUBERCULOSIS DISEASE.

**IV. MEDICAL CONDITIONS (✓)**

|                                 | Yes                      | No                       | If Yes, Explain: |
|---------------------------------|--------------------------|--------------------------|------------------|
| Allergies .....                 | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Asthma .....                    | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Cardiac .....                   | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Chemical Dependency .....       | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Drugs.....                      | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Alcohol .....                   | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Diabetes Mellitus .....         | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Gastrointestinal Disorder ..... | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Hearing Disorder .....          | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Hypertension.....               | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Neuromuscular Disorder.....     | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Orthopedic Condition .....      | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Respiratory Illness .....       | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Seizure Disorder .....          | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Skin Disorder .....             | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Vision Disorder.....            | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Other (Specify) .....           | <input type="checkbox"/> | <input type="checkbox"/> | _____            |

**V. PHYSICAL EXAMINATION (✓)**

|                               | NORMAL | ABNORMAL | NOT EXAMINED | COMMENTS |
|-------------------------------|--------|----------|--------------|----------|
| Height (inches)               |        |          |              |          |
| Weight (pounds)               |        |          |              |          |
| Pulse                         |        |          |              |          |
| Blood Pressure                |        |          |              |          |
| Hair/Scalp                    |        |          |              |          |
| Skin                          |        |          |              |          |
| Eyes – Visual Acuity: RL      |        |          |              |          |
| Eyes – Color Vision           |        |          |              |          |
| Ears – Hearing (dB) RL        |        |          |              |          |
| Nose and Throat               |        |          |              |          |
| Teeth and Gingiva             |        |          |              |          |
| Lymph Glands                  |        |          |              |          |
| Heart – Murmur, etc...        |        |          |              |          |
| Lungs – Adventitious Findings |        |          |              |          |

|                      |  |  |  |  |
|----------------------|--|--|--|--|
| Abdomen              |  |  |  |  |
| Genitourinary        |  |  |  |  |
| Neuromuscular System |  |  |  |  |
| Extremities          |  |  |  |  |

Are there any special medical problems or chronic diseases which require restriction of activity, medication which might affect his/her work role? If so, specify

Are there any special equipment or accommodations needed to enable this person to perform their duties? If so, specify

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Physician Name (Print) Signature of Examiner

Date

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Physician Address

The statements and answers as recorded above are full, complete and true to the best of my knowledge and belief. I understand that any false or misleading statements may cause termination of my employment.

I authorize the physician or other person to disclose any knowledge or information pertaining to my health to the employing authority for whom this examination is performed.

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Signature of Employee

Date