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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"Per the Genetic Information Nondiscrimination Act of 2008, it is unlawful for an employer to request genetic information, genetic testing information, family medical history information, or family genetic testing information from an applicant or employee. The medical provider conducting this examination of an applicant/employee of a local school district shall not request, require or purchase this information about the applicant or employee. Any applicant or employee undergoing a medical examination for employment with a local school district shall not provide this information to the medical provider or the school district."

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PHYSICAL

1. General Appearance ____________________
2 Eyes ____________________
3. Ears, Nose & Throat ____________________
4. Teeth & Gums ____________________
5. Thyroid ____________________
6. Heart ____________________
7. Blood Pressure __________ Pulse __________
8. Lungs ____________________
9. Abdomen ____________________
10. Nervous System ____________________
11. Extremities ____________________

Other ____________________

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Tuberculosis Risk Factor Assessment

Yes ☐ No ☐ High risk for Tuberculosis infection

Yes ☐ No ☐ Referred to local health department for further TB infection evaluation

Yes ☐ No ☐ Tuberculosis test performed (specify: _________TST/_________BAMT)

______________________________Date of chest X-Ray

☐ No further follow-up unless signs/symptoms of Tuberculosis infection develop

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:

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PLEASE COMPLETE THE BACK IF PLANNING TO DRIVE ANY DISTRICT VEHICLE

____________________ ____________________

Date of Examination Signature (Physician/PA/ARNP)

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Rev. 02/1/08

PLEASE COMPLETE IF PLANNING TO DRIVING ANY SCHOOL OR BOARD VEHICLE

Yes ☐ No ☐ Have you ever a seizure

Yes ☐ No ☐ Currently have a defibulator

Yes ☐ No ☐ Ever had a stroke or TIA

Yes ☐ No ☐ Currently wear mono-vision contact lenses

Yes ☐ No ☐ Currently take insulin

Vision ____/______

THIS PAGE MUST BE COMPLETED BY THE PHYSICIAN

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