Position_____

GLOUCESTER CITY SCHOOL DISTRICT

SCHOOL PERSONNEL HEALTH RECORD

I. Patient Information

Last Name First MI Sex Date of Birth

Social Security Number Phone Number

Mailing Address Street City State Zip

Usual Source of Medical Care Physician's Name Address Phone Number

Emergency Contact-Name Relationship Address Phone Number

II. Immunization History

VACCINE	Enter Month, Day, and Year Each Immunization was Given DOSES			BOOSTERS & DATES	
Diphtheria and Tetanus*	1.	2.	3.	4.	5.
Hepatitis B	1.	2.	3.		
Measles, Mumps, Rubella	1.	2.			
Other_____	1.	Other _____			

*Tetanus Diphtheria are usually combined vaccines such as DTP, DtaP, DT, or Td

III. Required Tuberculosis Test Results as per Regulations of the Department of Health

DATE APPLIED	ARM	METHOD	ANTIGEN	MANUFACTURE	SIGNATURE
DATE READ	**RESULTS (mm)**		**SIGNATURE**		

For previously known\new positive reactors: _____

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

Preventive Anti-Tuberculosis Chemotherapy ordered: F No F Yes Date:_____

IF SIGNIFICANT REACTION WAS REPORTED, THE PHYSICIAN REPORT MUST STATE THAT THE APPLICANT IF FREE FROM CURRENT TUBERCULOSIS DISEASE OT IS UNDER ADEQUATE CHEMOTHERAPY FOR TUBERCULOSIS DISEASE.

_____

_____

_____

IV. Significant Medical Conditions (9)

	No	IF Yes, Explain
Allergies	_____	_____
Asthma	_____	_____
Cardiac	_____	_____
Chemical Dependency	_____	_____
Drugs	_____	_____
Alcohol	_____	_____
Diabetes Mellitus	_____	_____
Gastrointestinal Disorder	_____	_____
Hearing Disorder	_____	_____
Hypertension	_____	_____
Neuromuscular Disorder	_____	_____
Orthopedic Condition	_____	_____
Respiratory Illness	_____	_____
Seizure Disorder	_____	_____
Skin Disorder	_____	_____
Vision Disorder	_____	_____
Other (Specify)	_____	_____

V. Report of Physical Examination (9)

	NORMAL	ABNORMAL	NOT EXAMINED	COMMENTS
Height (inches)				
Weight (pounds)				
Pulse				
Blood Pressure				
Hair\Scalp				
Skin				
Eyes Visual Acuity: R_____ L _____				
Eyes Color Vision				
Ears Hearing (Db) R_____ L _____				
Nose and Throat				
Teeth 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 or which might affect his\her work role? If so, specify_____

...

Physician Name (Print) Signature of Examiner Date

...

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 id performed.

_____

Signature of Employee Date