

**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.) _____

Surgical (All major operations) _____

Family History (T.B., Epilepsy, Diabetes, etc.) _____

PHYSICAL

- | | |
|------------------------------|-------------------------------------|
| 1. General Appearance _____ | 7. Blood Pressure _____ Pulse _____ |
| 2. Eyes _____ | 8. Lungs _____ |
| 3. Ears, Nose & Throat _____ | 9. Abdomen _____ |
| 4. Teeth and Gums _____ | 10. Nervous System _____ |
| 5. Thyroid _____ | 11. Extremities _____ |
| 6. Heart _____ | 12. Other _____ |

T.B. Skin Test
Date Given: _____
Type of Test: _____
Millimeters of Induration: _____

Date Read: _____
By Whom: _____

Date X-ray Taken: _____
OR

No further follow-up
necessary unless
signs/symptoms of
tuberculosis develop

TEAR OFF THIS PORTION AND RETURN TO SCHOOL SUPERINTENDENT'S OFFICE

CERTIFICATION OF MEDICAL EXAMINATION

This is to certify that 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: _____

Date of Examination

Signature (Physician/PA/ARNP)

*A separate form is provided for bus drivers.