MEDICAL EXAM/HEALTH CLEARANCE

THIS SECTION TO BE COMPLETED BY EMPLOYEE	
EMPLOYEE NAME-LAST, FIRST	SOCIAL SECURITY NUMBER

DO YOU HAVE OR HAVE YOU EVER BEEN TOLD THAT YOU HAVE:

	NO	YES	If YES, please explain.		NO	YES
• Allergies, Asthma, Wheezing				Have you ever been treated		
• Chronic, Cough, Colds				for any back disorder		
• Rheumatic Fever						
• Heart Trouble				Have you ever had treatment		
• High Blood Pressure				for a drug or alcohol		
• Frequent Headaches						
• Fainting or Dizziness				Need Hearing Aid?		
• Epilepsy or Convulsions				Use Hearing Aid?		
• Nervous Breakdown						
• Difficulty Hearing				Date of Last Eye Exam:		
• Difficulty Seeing						
• Hernia				Corrective Lenses		
• Diabetes						
• Varicose Veins				Do you have any physical		
• Productive Cough				limitations?		
• Night Sweats						
• Loss of Appetite				Do you take any prescribed		
• Recent, Unexplained Weight Loss				medication?		

Are you now in good health to the best of your knowledge? ☐ YES ☐ NO

Are you now under physician's care? ☐ YES ☐ NO

Name of Physician: _____

Address: _____

I HEREBY AUTHORIZE THE FOLLOWING REQUESTED INFORMATION TO BE RELEASED TO THE AGENCY.

_____ _____

SIGNATURE OF EMPLOYEE DATE

THIS SECTION TO BE COMPLETED AND SIGNED BY PHYSICIAN			
HEIGHT	WEIGHT	BP	

NOTE: Item 1 in the following list is required; items 2-8 are ☐ required ☐ may be completed in adherence to state and local agency requirements.

	Positive	Negative	Clinical Results	Date
1) PPD and/or Chest X-ray				
2) Serology (VDRL)				
3) CBC				
4) Urinalysis				
5) Immunizations (Specify)				
6) Other				
7) Varicella Titre		**Immune**	**Non-Immune**	
8) Rubeola Titre		**Immune**	**Non-Immune**	
9) Rubella Titer		**Immune**	**Non-Immune**	

I have interviewed the above-named individual concerning the items addressed above and have responded according to the information received.

☐ No Limitations ☐ Limitations _____

I have examined the above-named individual and have found her/him to be in good health and free from communicable diseases. There are no abnormalities that would keep this individual from performing as a health care worker.

Physician Signature: _____ Date of Physical Exam: _____