H511.340 (Rev. 5/2019)

# 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:
(Home) (Work) (Cell)

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

| VACCINE<br>Check appropriate box | Enter Month, Day, and Year 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:
(Attach a copy of the report.)

Other: Date: Results:
(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.

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## IV. MEDICAL CONDITIONS (✓)

| | Yes | 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. 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 – Adventious 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

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 is performed.

Signature of Employee Date