DEPARTMENT OF EDUCATION
HUMAN RESOURCES DIVISION

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Personnel Services Administrator

Report of Medical Examination

IMPORTANT: This report of Medical Examination must be completed and submitted within 60 days of your effective date of hire.

Issue Date: _____ Due Date: _____

Date of Examination: _____

1. Name (Last, First & Middle Initial):				**2. Current Position Title:**
3. Residential Address:				**4. Sex: [ ] Male [ ] Female**
5. Race:	**6. Date of Birth:**			**7. Place of Birth:**
8. Next of Kin (Please indicate Name & Relationship):				
9. Next of Kin's Address:				
ALL ITEMS BELOW ARE TO BE COMPLETED BY PHYSICIAN ONLY				
10. Height	**11. Weight**	**12. Hair Color**	**13. Eye Color**	**14. Build** [ ] Slender [ ] Medium [ ] Heavy [ ] Obese
15. Hearing: RT WV/155 v/15 LT WV/155 v/15		**16. Vision:** RT 20/Correct to 20/20: LT 20/Correct to 20/20:		**17. Temperature:**
18. Respiration:	**19. Blood Pressure: (Arm at Heart Level)**			**20. Pulse: (Heart Low)**
	Sitting	**Sys Dias**	**Recumbent**	**2 Minutes After Exercise – Standing** / **2 Minutes After Exercise – Sitting**

21. Clinician Evaluation: Please check appropriate box and describe any abnormality as applicable.

Area of Examination	Normal	Abnormal	Not Examined	Description of Abnormality
Head, Face, Neck & Scalp				
Nose, Mouth, Throat				
Sinuses				
Ears – General (Internal & External Canal) (Acoustic Acuity -Item 15)				
Drums (Perforation)				
Eyes – General (Visual Acuity - Item 16)				
Opthalmoscopic Exam				
Pupils (Equality & Reaction)				
Ocular Movement				
Lungs & Chest				
Breast				

Name (Please Print): _____

Area of Examination	Normal	Abnormal	Not Examined	Description of Abnormality
Heart				
Vascular System				
Abdomen				
Anus, Rectum				
Endocrine				
G-U System				
Upper Extremities				
Lower Extremities				
Feet				
Spine & Other Musculoskeletal				
Identifiable Body Marks, Scars, Tattoos				
Skin / Lymphatic				
Pelvic / Pap (Females Only)				
Prostate (Males Only)				

22. Laboratory Findings

CBC (No Differential) Date:	Fasting Blood Sugar Date:	Urinalysis Date:	Hemo-cult Date:
Hepatitis Screening Date:	Cholesterol Date:	Chest X-Ray Date:	Other Test: Date:

Remarks: Clinical Evaluation Comments, Recommendations, Summary of Mental or Physical Defects & Diagnosis: (Use additional sheets of plain paper if necessary)

Based on the result of the examination, the examinee: Examinee [ ] Does meet [ ] Does Not meet (indicate appropriate box) health and physical condition standard deemed necessary and proper for the performance of the duties and responsibilities of position indicated under item number 2.

Print Name of Examining Physician:

Signature of Examining Physician: **Date:**

Address of Examining Physician (Number, Street, and Village or RFD City, State)