Marion Center Area School District

SCHOOL PERSONNEL HEALTH RECORD

I. Patient Information

Last Name First **MI** Sex D.O.B.

Social Security Number Home Telephone Work Telephone

Mailing Address Street City Zip

Usual Source of Medical Care Physician's Name Address Telephone

Emergency Contact - Name Relationship Address Telephone

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	/ /	Other		/ /	
*Tetanus and Diphtheria are usually received in combined vaccines such a **DTP, DPTaP, or Td**					

III. Required Tuberculosis, if applicable. Test Results (as per Regulations of the Department of Health)

Date Applied	Arm	Method	Antigen	Manufacturer	Signature
Date Read	Results (mm)		Signature		

For 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 ❑ No ❑ Yes Date:_____

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

H511.340 (Rev. 4/00)

IV. **Significant Medical Conditions** (✓)

	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 V)

	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 and Gingiva				
+ Lymph Glands				
• Heart - Murmur, etc.				
• Lung - Adventious 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 is performed.

Signature of Employee | Date