**PRE-EMPLOYMENT PHYSICAL**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male \_\_\_\_\_\_ Female \_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# (Last 4 digits): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Practitioner**: Please complete the following:

Height: \_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_ BP: \_\_\_\_\_\_\_\_\_ T.P.R \_\_\_\_\_\_\_\_\_

1. **Immunizations and Lab Tests:**

|  |  |
| --- | --- |
| \* PPD # 1(Mantoux) Pos Neg | Date Implanted: \_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Date Read: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \* PPD # 2: (Mantoux) Pos Neg | Date Implanted: \_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Date Read: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Chest X-ray: (If PPD is positive) Pos Neg   (Attach lab report)  | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \* Rubella Pos Neg | Titer: \_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_ |
| \* Rubeola (if born after 12/31/56) Pos Neg  | Titer: \_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ |
| * MMR Vaccine (alternate for Rubella & Rubeola)      * Varicella Vaccine Date: \_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ |

* + Hepatitis B Vaccine (optional) #1 Date: \_\_\_\_\_\_\_ #2 Date: \_\_\_\_\_\_\_ #3 Date: \_\_\_\_\_\_\_\_Titer: \_\_\_\_\_\_\_\_

Medical Exemption from Influenza Vaccine:

Yes (complete attached exemption form) No (complete information below)

* + Seasonal Influenza Vaccine (for applications from Sept. to Mar.) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Manufacturer & Lot #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Site of Administration: \_\_\_\_\_\_\_\_\_\_\_\_

Person administering the vaccine:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reactions (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Review of Systems:**

|  |  |  |
| --- | --- | --- |
| Cardiovascular \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Muscular \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Digestive \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Nervous \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Endocrine \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Reproductive \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Excretory \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Respiratory \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Immune \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Skeletal \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Present Medication(s): Yes No (If yes, attach list of medications, dosages, and purpose)

**Please turn over**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# (Last 4 digits): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **2. Past Medical History** | **YES NO** |
| Any serious problems, surgery |  |
| Tuberculosis |  |
| Diabetes |  |
| Mental/Behavioral Disorder |  |
| Cardiovascular Disease |  |
| Hypertension/Hypotension |  |
| Asthma |  |
| Epilepsy/Seizure Disorder |  |
| Cancer |  |
| Kidney Disease |  |
| Drug/Alcohol Abuse |  |
| Allergies |   |
| Other **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |
| **3. Tuberculosis (TB) Questionnaire/Screening** | **YES NO** |
| Exposure to TB at Work/Home |  |
| Positive Chest X-Ray |  |
| Unintended Weight Change (+/- 10 lbs) |  |
| Persistent Cough |  |
| Conversion to Positive PPD |  |
| Low Grade Fever |  |
| Unexplained fatigue |  |
| Blood Streaked Sputum |  |
| Active TB |  |
| Night Sweats |  |
| Loss Appetite |  |
| Clear, Yellow or Dark Sputum |  |

I certify that I have examined the above-named individual and found him/her to be free of any addiction/ habituation to depressants, stimulants, narcotics, illegal drugs, or alcoholic substances. Yes No 

I certify that I have examined the above-named individual and found him/her to be:

[ ] Fully Employable – No limitations

[ ] Employable – Suggest Follow Up and/or completion of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Not Currently Employable – Recommend Additional Testing /Treatment and/or Follow Up as soon as possible for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Practitioner’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Office Stamp:**

License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please note:**

* **Physical is not acceptable without Medical Practitioner’s stamp; which includes practitioner’s name, address, phone # and license #. Form must be stamped and signed.**
* **If applicable, a copy of Chest X-Ray Report must be attached**