**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**