TEACHER PHYSICAL FORM

NAME: _____ BIRTHDATE: ____-____-____

(Please print) First Middle Last Month - Day - Year

PHONE #: ( ) ____-____ UIN: _____ SEX: Male / Female

TO BE COMPLETED BY EMPLOYEE:

To the best of your knowledge do you have or have you had any disease or disorder of the following:

1. Impaired health at present time?	Yes / No	14. Tuberculosis?	Yes / No
2. Heart, blood or blood vessels?	Yes / No	15. Pleurisy, asthma or emphysema?	Yes / No
3. Rheumatic fever or heart murmur?	Yes / No	16. Esophagus, stomach or intestines?	Yes / No
4. Abnormal heart rate or rhythm?	Yes / No	17. Liver or gallbladder?	Yes / No
5. High blood pressure?	Yes / No	18. Ulcer or colitis?	Yes / No
6. Diabetes or gout?	Yes / No	19. Genito-urinary system?	Yes / No
7. Thyroid or glands?	Yes / No	20. Kidneys or bladder?	Yes / No
8. Skin, muscles, bones or joints?	Yes / No	21. Brain or nervous system?	Yes / No
9. Arthritis?	Yes / No	22. Dizziness or unconsciousness?	Yes / No
10. Eyes; uncorrected visual defect?	Yes / No	23. Mental illness, epilepsy or paralysis?	Yes / No
11. Ears; impaired hearing?	Yes / No	24. Encephalitis or neuritis?	Yes / No
12. Cancer or tumor?	Yes / No	25. Alcoholism or drug use?	Yes / No
13. Lungs or bronchi?	Yes / No	26. Taking any medications?	Yes / No

LISTING BY NUMBER, DESCRIBE BELOW ALL QUESTIONS ANSWERED "YES":

Question Number	Pertinent history to include dates, severity and outcome

NAME _____

TO BE COMPLETED BY PROVIDER:

(Accepted providers include MD and NP)

Vital Signs: Height _____ in. Weight _____ lbs.

Temperature _____ Pulse _____ Respirations _____ Blood Pressure _____

Urine Dip: Description _____ Specific Gravity _____

Leukocytes _____ Nitrite _____ Protein _____ pH _____ Blood _____ Ketone _____ Glucose _____

T.B. test: _____ _____ _____ mm Negative / Positive

Date placed | Date of reading | Result

General Appearance	Normal / Abnormal	**REMARKS AND DETAILS OF POSITIVE / ABNORMAL FINDINGS**
Eyes	Normal / Abnormal	
Ears	Normal / Abnormal	
Nose	Normal / Abnormal	
Throat	Normal / Abnormal	
Neck	Normal / Abnormal	
Lymph Nodes	Normal / Abnormal	
Lungs	Normal / Abnormal	
Cardiovascular	Normal / Abnormal	
Reflexes	Normal / Abnormal	
Musculoskeletal	Normal / Abnormal	
Abdomen	Normal / Abnormal	
Neurological	Normal / Abnormal	
Skin	Normal / Abnormal	
Genito-urinary	Normal / Abnormal	

Do you consider applicant to be in good health? Yes / No

_____ Date of Exam

_____ Printed Name of Provider _____ Provider's State License Number

_____ Provider's Signature

_____ Address _____ State _____ Zip Code

_____ Telephone Number _____ Fax Number