KENTUCKY DEPARTMENT OF EDUCATION
MEDICAL EXAMINATION OF SCHOOL EMPLOYEES*

Name ______________________ **Date of Birth** ____/____/____ **Sex: M** ☐ **F** ☐

Address ______________________ **Telephone** ______________

Applicant With Or Employed By ______________________ **Board of Education**

HISTORY

Medical (All serious medical and psychiatric diseases: Diabetes, Epilepsy, Heart Disease, etc. ______________

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Surgical (All major operations) ______________________

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Family History (T.B., epilepsy, Diabetes, etc.) ______________________

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PHYSICAL

1. General Appearance ______________
2 Eyes ______________
3. Ears, Nose & Throat ______________
4. Teeth & Gums ______________
5. Thyroid ______________
6. Heart ______________
7. Blood Pressure ________ Pulse ________
8. Lungs ______________
9. Abdomen ______________
10. Nervous System ______________
11. Extremities ______________

Other ______________

____

Tuberculosis Risk Factor Assessment

Yes ☐ No ☐ High risk for Tuberculosis infection

Yes ☐ No ☐ Referred to local health department for further TB infection evaluation

Yes ☐ No ☐ Tuberculosis test performed (specify: ________TST/________BAMT)

________________________Date of chest X-Ray

☐ No further follow-up unless signs/symptoms of Tuberculosis infection develop

I have examined ______________________ and find him/her free of communicable disease and any physical or mental disabilities that might interfere with performing his/her duties, except as follows:

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______________________ Date of Examination

______________________ Signature (Physician/PA/ARNP)

* A separate form is provided for bus drivers

Rev. 2/1/08