MANSFIELD TOWNSHIP SCHOOL DISTRICT

John Hydock Elementary School
19 Locust Avenue, Columbus NJ 08022

Mansfield Township Elementary School
200 Mansfield Road East, Columbus NJ 08022

HEALTH ASSESSMENT – CANDIDATE FOR EMPLOYMENT

PLEASE PRINT

Name: ______________________ Date of Birth: ______________

Address: ______________________________________

Position: ______________________ Building: ______________

Private Physician: ______________________ Physician's Phone: ______________

Physician's Address: ______________________________________

HEALTH HISTORY

To be *completed by candidate. To be <u>REVIEWED BY AND SIGNED-OFF BY PHYSICIAN</u>.*
Indicate yes/no and explain all" yes" responses on the lines below

Allergies	**YES**	**NO**	**Head/brain injuries or disorders**	**YES**	**NO**
Diabetes	**YES**	**NO**	**Eye disorders/impaired vision**	**YES**	**NO**
Digestive problems	**YES**	**NO**	**Seizures, epilepsy**	**YES**	**NO**
Fainting, dizziness	**YES**	**NO**	**Ear disorders, loss of hearing or balance**	**YES**	**NO**
Kidney disease	**YES**	**NO**	**Heart condition/disease**	**YES**	**NO**
Liver disease	**YES**	**NO**	**High blood pressure**	**YES**	**NO**
Lung disease, asthma respiratory condition	**YES**	**NO**	**Stroke or paralysis**	**YES**	**NO**
Musculoskeletal problems	**YES**	**NO**	**Nervous or psychiatric disorder**	**YES**	**NO**

List any other significant health problems/injuries: ______________________________
____

Explain all "yes" answers here: ______________________________
____
____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I AM PHYSICALLY ABLE TO PERFORM ALL THE DUTIES REQUIRED BY THIS POSITION.

______________________ ______________________________
Date Signature of Employment Candidate

______________________ ______________________________
Date Signature of Physician

PHYSICAL EXAMINATION

To be *completed by the physician*: **ALL ITEMS MUST BE COMPLETED**

Height:_______ Weight: _______ Blood Pressure: _________ Vision: ________ Hearing: _________

PHYSICAL EXAMINATION: (Circle N = Normal OR AB = Abnormal must comment on all AB designations)

Head/Neck	**N**	**AB**	**Abdomen assessment (liver, spleen)**	**N**	**AB**
Eyes/Sclera/Pupils	**N**	**AB**	**Neck, Back, Spine ROM**	**N**	**AB**
Ears	**N**	**AB**	**Upper extremities**	**N**	**AB**
Nose/Mouth/Throat	**N**	**AB**	**Lower Extremities**	**N**	**AB**
Heart/Murmur/Rhythm	**N**	**AB**	**Neurological (balance, coordination)**	**N**	**AB**
Lungs	**N**	**AB**	**Genitourinary (hernia)**	**N**	**AB**
Chest Contour	**N**	**AB**	**Skin**	**N**	**AB**

COMMENTS:____

____

TESTS/IMMUNIZATIONS

1. Hepatitis B Series: Hep #1________ Hep #2________ Hep #3________
   Required for nurse, employees who cover health office, principals, custodians, physical education teachers, one-on-one aides (based upon evaluation of student behaviors that may indicate risk to employee), employees of the preschool handicapped program.

2. Adult Tetanus:_______________(required for custodians or cafeteria employees every 10 years)
   Date of last Tetanus Toxoid Booster_______________
   Comments:____

3. Mantoux (PPD) for Tuberculosis: _______________ _______________
   Date Result

General Health (circle one): GOOD FAIR POOR

I certify that this person is physically ABLE UNABLE (circle one) to perform all the duties required by his/her position – see job description, if provided.

____
Signature of Physician

____
Date of Examination

____
***PRINTED* Name of Physician**

This information may be reviewed by school physician and/or designee.

Rev. 02/13/09