



Rebecca School NEW EMPLOYEE Health Examination Form

Section I: This section is to be completed by the employee.

Name: _____

Date of Birth: _____

Telephone: _____

Gender: Male Female

Job Title: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Telephone: _____

Section II: This section is to be completed by the provider.

ALLERGIES

Drug Allergy	Y	N	Specify:
Food Allergy	Y	N	Specify:
Other	Y	N	Specify:

PAST MEDICAL HISTORY

Hypertension	Y	N	Comments:
Heart Disease	Y	N	Comments:
Diabetes	Y	N	Comments:
Seizure Disorder	Y	N	Comments:
Chronic Lung Disease	Y	N	Comments:
Mental Illness	Y	N	Comments:
Alcohol Abuse	Y	N	Comments:
Substance Abuse	Y	N	Comments:
Physical Disabilities	Y	N	Comments:
Allergies	Y	N	Comments:
Hepatitis	Y	N	Comments:
Other:	Y	N	Comments:

PHYSICAL EXAMINATION

Ht:	Wt:	BP:	HR:	Temp:
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PPD SKIN TEST

MANTOUX SKIN TEST	QUANTIFERON	CHEST X-RAY
Test Date: _____	Collection date: _____	Date of X-Ray: _____
Placed by: _____		
Date Read: _____	RESULT	RESULT
Read by: _____		
RESULT	Interpretation:	Impression:
Induration:		
<input type="checkbox"/> Positive <input type="checkbox"/> Negative		
*Chest X-Ray required if positive result		

IMMUNIZATIONS

Documentation of Immunity	Vaccine Name	Vaccine #1	Vaccine #2	Blood Test Documenting Immunity (Titers)	Provider-Documented History of Illness
Tdap (Tetanus-diphtheria-acellular pertussis)					
Rubella					
Measles*					
Mumps*					
Varicella*					

*Two doses of vaccine are required at least 28 days apart

I hereby certify that I have examined the above employee and the above is a complete and accurate assessment of my examination. I hereby state that this employee is in good health which is required to perform the essential functions of the position listed above.

Physician Name (print): _____ Lic #: _____

Telephone: _____

Physician Signature: _____ Date: _____