SUMTER COUNTY SCHOOLS
2680 WC 476, Bushnell, FL 33513
Phone #: 352-793-2315 X252

PHYSICAL EXAMINATION

Date :

Last Name	First Name	Middle Name	Date of Birth

Address (No, Street, City, State, Zip Code)

Telephone Number (Home)	Telephone Number (Cell)	Employment Position

SECTION I: Health History Review — The following information is needed to assist the physician in determining each employees condition of health.) Please complete this section BEFORE examination.

1. Have you had any major illnesses or injuries in the last (5) years? If so, explain: _____
2. Do you have any disabilities or impairments which may affect your job performance? If so, explain: _____
3. Are you taking any routine medications? If so, state medication and reason: _____
4. Have you ever been treated by a psychiatrist or psychologist? If so, for what condition? If no such treatment has been received, state "None" _____
5. Have you ever been treated for drug addition or alcoholism? If yes, identify the medical care provider and dates of treatment. If no treatment has been provided, state "None" _____
6. Have you ever filed a Workers' Compensation claim? _____

Have you ever had or been treated for any of the following conditions or diseases? Mark **YES** or **NO**
If you answer YES to any of the questions below, please explain treatment.

YES	NO	
		1. High blood pressure
		2. Diabetes
		3. Heart problems
		4. Chest pain
		5. Allergies
		6. Asthma / Hay fever
		7. Shortness of breath
		8. Tuberculosis
		9. Chronic cough
		10. Epilepsy
		11. Fainting spells
		12. Severe headaches / Migraines
		13. Head / Neck injury
		14. Back injury
		15. Joint injury / Broken bones
		16. Cancer
		17. Tumors
		18. Ulcers
		19. Kidney / Bladder problems
		20. Anemia
		21. Arthritis / Rheumatism
		22. Varicose veins
		23. Skin conditions
		24. Eye / Vision trouble
		25. Hearing trouble
		26. Emotional problems
		27. Any invertebral (spine) disorders

EMPLOYEE'S STATEMENT:

I hereby certify that the above statements are true and correct to the best of my knowledge and belief. I have included all previous existing physical ailments or conditions that could affect my job performance.

_____
Signature of Employee

_____
Date

SECTION II: To be completed by Physician: (Physical Examination must be performed by licensed physician, nurse practitioner or physician's assistant.)

Name of Employee:_____ Date of Examination:_____

Height:_____ Weight:_____ Temperature:_____

Pulse:_____ Respiration:_____ B/P:_____

Allergies:_____ General Appearance:_____

(If blood pressure is abnormal, please indicate type of medication or recommended treatment) _____

_____

Review of Systems:	Normal	Abnormal	If Abnormal—Explain:
Skin			
Eyes			
Ears			
Nose			
Throat/Mouth			
Cardiovascular (heart and Chest)			
Lungs/Respiratory			
Gastro-Intestinal (abdomen)			
Neurological			
Musculoskeletal (back)			
Other			

Summary of findings/Remarks:_____

Please indicate, in your medical opinion, if this employee can perform the essential functions of the position for which he/she is applying. _____

If any restrictions noted, please indicate: _____

_____

Medical License Number:_____ State:_____

Print Name:_____ M.D. / D.O. ARNP / P.A.

Signature:_____

Address:_____ City:_____ State:_____ Zip:_____

Telephone Number:_____ Fax Number:_____

Office Stamp: