Audubon Public School District
Employee Physical Examination Form A

Last Name: _____

First Name: _____

Social Security Number: _____-_____-_____

Address: _____

_____

Phone: ( ) _____ - _____

Email: _____

- As a condition for employment in the Audubon Public School District you must **successfully** pass an examination to determine that you are in good health and free of tuberculosis. In addition, **your physician must provide the results of your TB skin test or chest x-ray, as well as the date on which it was performed, and read, within the last 90 days to comply with New Jersey Administrative Code.**
- I hereby give consent to have further information that is requested by the Audubon Public School District employee health services and/or school physician released by the physician that examined me.
- I certify that my responses on the Employee Medical History Forms are complete and true to the best of my knowledge. Any falsification or misrepresentation will be sufficient grounds for my release from employment.

_____ _____

Signature of Employee Date

To Be Completed by Physician

(Physical examination must be completed by a physician licensed in New Jersey or any other state to practice medicine and surgery)

Past Medical Hx: _____

_____

_____

Past Surgical Hx: _____

_____

_____

Medications (include OTC products): _____

_____

_____

Allergies (include drug, food, and environmental: _____

_____

_____

Social Hx: _____

_____

_____

Family Hx: _____

_____

_____

Audubon Public School District
Employee Physical Examination Form A

PPD/Mantoux Test for Tuberculosis:

Date Applied: _____

Date Read: _____

Results (millimeter of induration): _____

Chest X-Ray: Date Performed: _____ Results: _____

Summary of Overall Physical Examination: _____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby certify that I have examined the aforementioned applicant and the above is complete and accurate record of my examination. By checking "Yes" below, I hereby state that this employee is in good physical and mental health which is required to perform the essential functions of the position for which he/she is applying.

THIS APPLICANT IS FIT FOR EMPLOYMENT: ☐ Yes ☐ No *Deferred for Functional Capacity Evaluation:* ☐

Medical License Number: _____ Date: _____

Print Name: _____

Address: _____ Signature: _____

_____ Phone: _____

_____ Fax: _____

BOE Approved 08/21/2019

Audubon Public School District
Employee Physical Examination Form B
(To Be Completed by Employee and Shared with Physician)
Personal Medical History for the Previous 365 Days - **CHECK ALL THAT APPLY**

Head/Neck
- ☐ Concussion
- ☐ Dizzy Spells/ Seizures
- ☐ Fainting
- ☐ Headaches/Migraine
- ☐ Neck Injuries
- ☐ Other _____

Eyes
- ☐ Blurred Vision
- ☐ Change in Vision
- ☐ Color Deficiency
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Eye Surgery/Lasik
- ☐ Flashes of Light
- ☐ Glasses/Contacts
- ☐ Partial Loss of Vision
- ☐ Other_____
- ☐ Last Eye Exam:

Ears
- ☐ Difficulty Clearing Sinuses/Ears
- ☐ Discharge
- ☐ Frequent Earache
- ☐ Frequent Itching in Ears
- ☐ Hearing Aid
- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Ruptured Eardrum
- ☐ Other _____

Nose/Throat
- ☐ Bleeding Gums
- ☐ Difficulty Swallowing
- ☐ Enlarged Glands
- ☐ Fractured Nose
- ☐ Frequent Sinusitis
- ☐ Frequent Sore Throats
- ☐ Loss of Smell
- ☐ Nose Bleeds
- ☐ Persistent Hoarseness
- ☐ Other _____

Heart/Circulation
- ☐ Angina
- ☐ Ankle/Leg Swelling
- ☐ Arrhythmia
- ☐ Chest Pain on Exertion
- ☐ Chest Pain, Pressure, or Tightness
- ☐ Heart Attack
- ☐ Heart Disease/Disorder
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Heart Valve Disorder
- ☐ High Blood Pressure
- ☐ Leg Cramp When Walking
- ☐ Night Cough
- ☐ Palpitations/Flutters
- ☐ Persistent Fatigue
- ☐ Radiating Chest Pain to Arms, Jaw, Neck, Back
- ☐ Shortness of Breath
- ☐ Shortness of Breath on Lying Down
- ☐ Varicose Veins
- ☐ Rigid/Irregular Pulse
- ☐ Other _____

Gastrointestinal
- ☐ Abdominal Pain after Meals
- ☐ Bariatric Surgery
- ☐ Bloating/Gas/Cramping
- ☐ Bloody or Painful BM
- ☐ Change in Bowel Habits
- ☐ Weight Loss
- ☐ Food Intolerance
- ☐ Heartburn/Indigestion
- ☐ Hemorrhoids
- ☐ Hiatal Hernia
- ☐ History of Polyps
- ☐ Nausea/Vomiting
- ☐ Change in Size of Stool
- ☐ Persistent Diarrhea
- ☐ Reflux
- ☐ Other _____

Urinary
- ☐ Blood in Urine
- ☐ Burning on Urination
- ☐ Difficulty Starting/Stopping
- ☐ Dripping
- ☐ Erectile Dysfunction
- ☐ Kidney/Bladder Stones
- ☐ Nighttime Frequency
- ☐ Sexually Transmitted Disease
- ☐ Other _____

Lungs
- ☐ Abnormal Chest X-ray
- ☐ Asbestosis Exposure
- ☐ Asthma/Wheezing
- ☐ Chest Pain with Deep Breath
- ☐ Chronic Bronchitis
- ☐ Chronic Cough
- ☐ Cough when lying down
- ☐ Coughing at Night
- ☐ Coughing Blood in Last Month
- ☐ Daytime Drowsiness
- ☐ Early Morning Cough
- ☐ Emphysema
- ☐ Night Sweats
- ☐ Pneumonia/Pleurisy
- ☐ Pneumothorax/Collapsed Lungs
- ☐ Productive Cough
- ☐ Shortness of Breath
- ☐ Shortness of Breath while walking fast or up slight incline
- ☐ Shortness of Breath while walking with others at ordinary pace on level ground
- ☐ Shortness of Breath while washing/dressing
- ☐ Shortness of Breath that interferes with job
- ☐ Occupational Exposure
- ☐ Snoring
- ☐ Shortness of Breath while walking at your own pace on level ground
- ☐ Tuberculosis
- ☐ Prescribed Inhalers
- ☐ Other _____

Menstrual History
- ☐ Abnormal Pap
- ☐ Anemia
- ☐ Breast Lumps
- ☐ Heavy Bleeding
- ☐ Hot Flashes/Sweats
- ☐ Irregular Cycle
- ☐ Pregnancy Complication
- ☐ Severe Cramping
- ☐ Spotting
- ☐ Vaginal Discharge
- Other _____

Spine Extremities
- ☐ Amputation
- ☐ Backache/Injury
- ☐ Difficulty Bending at the knees
- ☐ Difficulty Climbing a flight of stairs or ladder carrying more than 25 lbs
- ☐ Difficulty Fully Moving Your Head Up/Down
- ☐ Difficulty Fully Moving Your Head Side to Side
- ☐ Difficulty Squatting to Ground
- ☐ Dislocation
- ☐ Fractures
- ☐ Joint Pain
- ☐ Joint Swelling/redness/heat
- ☐ Sprain/Strains
- ☐ Weakness of Hands/Feet
- ☐ Numbness/tingling of Extremities
- ☐ Other _____

Thyroid
- ☐ Brittle Nails/Hair
- ☐ Decrease/Increase in Appetite
- ☐ Goiter
- ☐ Hand Tremor
- ☐ Heat/Cold Intolerance
- ☐ Rapid/Slow Heartbeat
- ☐ Thyroid Nodule
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Other _____

Substances
- ☐ Smoke Cigarettes
  Packs per day _____
- ☐ Drink Alcohol
  Amount per day _____
- ☐ Smoke Cigars
  Packs per day _____
- ☐ Chew Tobacco
  Amount per day _____
- ☐ Drug Dependency
- ☐ Treatment for Alcoholism
- ☐ Other _____

Employee's Signature: _____ Date: _____

Board Approved 08/21/19