CALDWELL-WEST CALDWELL PUBLIC SCHOOLS
HEALTH AND MEDICAL HISTORY FORM

TO BE COMPLETED BY EMPLOYEE: **DATE OF HIRE:**

NAME:		**TELEPHONE #**	**DATE OF BIRTH:**
ADDRESS	**POSITION APPLYING FOR AND SCHOOL ASSIGNED TO:**		

HEALTH HISTORY : If YES, please explain:

Chronic or recurring illness/condition	No	Yes	______
Asthma	No	Yes	______
Diabetes	No	Yes	______
Epilepsy/Seizures/Blackouts	No	Yes	______
Cardiac/Heart Disease	No	Yes	______
Hypertension	No	Yes	______
Bleeding Disorder	No	Yes	______
Frequent Headaches	No	Yes	______
Skin Disorder	No	Yes	______
Gastrointestinal Disorders	No	Yes	______
Neuromuscular Disorder	No	Yes	______
Orthopedic Condition	No	Yes	______
Respiratory Illness	No	Yes	______
Mental/Emotional Issues	No	Yes	______
Dental/Orthodontic Appliances	No	Yes	______
Hearing Problems	No	Yes	______
Vision Problems (glasses or contacts)	No	Yes	______
Hospitalizations/Surgeries	No	Yes	______
Recent injury, illness, infectious disease	No	Yes	______
Other ______			______

OTHER SIGNIFICANT MEDICAL INFORMATION THE DISTRICT SHOULD KNOW ABOUT:

Signature : ______ Date: ______

Witness: ______

10/14

CALDWELL-WEST CALDWELL PUBLIC SCHOOLS
PHYSICAL EXAMINATION

PHYSICAL EXAMINATION TO BE COMPLETED BY PHYSICIAN.

NAME:	POSITION:	DATE OF BIRTH:

HEALTH HISTORY:

ALLERGIES: List all known allergies: Describe reaction and management of reaction.

Medication Allergies: Yes No ______________ ______________

Food Allergies: Yes No ______________ ______________

Insects/Animals: Yes No ______________ ______________

Environmental/ Pollens: Yes No ______________ ______________

MEDICATIONS: List all medications (prescription, over-the-counter, non-prescription) taken routinely.

Medication	Dosage/Frequency	Reason for medication

HEIGHT:	WEIGHT:	B/P:	HEART RATE:

	NORMAL	COMMENTS: (EXPLAIN ALL ABNORMAL FINDINGS)
APPEARANCE		
SKIN		
EYES/EARS/NOSE/THROAT		
LYMPH NODES		
HEART		
LUNGS		
ABDOMEN		
GENITOURINARY		
CNS		
NEUROMUSCULAR		
MUSCULO-SKELETAL		
EXTREMITIES		
SPINE		

VISION: O.D. 20/ O.S. 20/ O.U. 20/

HEARING: RIGHT LEFT

KNOWN VISION OR HEARING PROBLEM

I CERTIFY THE ABOVE NAMED PERSON IS PHYSICALLY ABLE TO PERFORM THE DUTIES REQUIRED IN THE POSITION THEY ARE BEING HIRED FOR : YES ☐ NO ☐

PHYSICIAN'S NAME AND ADDRESS (PLEASE PRINT):	PHYSICIAN'S SIGNATURE:
TELEPHONE NUMBER:	DATE OF EXAMINATION:

Physical exam form must be completed in full.