

**KENTUCKY DEPARTMENT OF EDUCATION**  
**MEDICAL EXAMINATION OF SCHOOL EMPLOYEES\***

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M  F

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Applicant With Or Employed By \_\_\_\_\_ Board of Education

**HISTORY**

**Medical** (All serious medical and psychiatric diseases: Diabetes, Epilepsy, Heart Disease, etc. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Surgical** (All major operations) \_\_\_\_\_  
\_\_\_\_\_

**Family History** (T.B., epilepsy, Diabetes, etc.) \_\_\_\_\_  
\_\_\_\_\_

**PHYSICAL**

- |                              |                                     |
|------------------------------|-------------------------------------|
| 1. General Appearance _____  | 7. Blood Pressure _____ Pulse _____ |
| 2. Eyes _____                | 8. Lungs _____                      |
| 3. Ears, Nose & Throat _____ | 9. Abdomen _____                    |
| 4. Teeth & Gums _____        | 10. Nervous System _____            |
| 5. Thyroid _____             | 11. Extremities _____               |
| 6. Heart _____               | Other _____                         |

**Tuberculosis Risk Factor Assessment**

Yes  No  High risk for Tuberculosis infection

Yes  No  Referred to local health department for further TB infection evaluation

Yes  No  Tuberculosis test performed (specify: \_\_\_\_\_TST/\_\_\_\_\_BAMT)

\_\_\_\_\_ Date of chest X-Ray

No further follow-up unless signs/symptoms of Tuberculosis infection develop

I have examined \_\_\_\_\_ and find him/her free of communicable disease and any physical or mental disabilities that might interfere with performing his/her duties, except as follows:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date of Examination

\_\_\_\_\_  
Signature (Physician/PA/ARNP)

\* A separate form is provided for bus drivers