NOTE: Do not bill school district. Employee is responsible for all charges.

ONEIDA SPECIAL SCHOOL DISTRICT
Oneida, Tennessee 37841

EMPLOYEE MEDICAL EXAMINATION FORM

Name ____________________ **Date** ____________________
Address ____
Age ____________________ **Phone** ____________________

MEDICAL HISTORY: Any history of the following diseases (Yes or No):

Heart ____________ **Lungs** ____________ **Kidney** ____________
Diabetes ____________ **Head, Bone or Joint Injury** ____________
High Blood Pressure ____________ **Epilepsy or Convulsion** ____________

COMMENTS: ____
____
____

EXAMINATION:

Development Build ____________ **BP:** ____________ **P:** ____________
EENT ____________ **Heart** ____________
Lungs ____________ **Abdomen** ____________
Hernia ____________ **Orthopedic** ____________
Urine: Sug ____________ **ALB:** ____________

COMMENTS: ____
____
____

TB Tine Test: Date ____________ **Positive** ____________ **Negative** ____________

This is to certify that I have examined the above individual and find him/her free of communicable disease and any physical or mental disability that might interfere with his/her duties, requiring work with children of all ages.

____________________ ____________________
Physician's Signature **Address**

____________________ ____________________
Telephone