H511.340 (Rev. 5/2019)

SCHOOL PERSONNEL HEALTH RECORD
(FOR USE AFTER OFFER OF EMPLOYMENT HAS BEEN MADE)

I. INFORMATION

School Position Offered _____

Last Name First MI Sex Date of Birth

Home Phone Cell Phone Work Phone

Mailing Address: Street City State Zip

Emergency Contact

Name: Relationship:

Address:

Telephone number:
(Home) (Work) (Cell)

II. IMMUNIZATION HISTORY (Recommended, but not mandated by law)

VACCINE Check appropriate box	Enter Month, Day, and Year Each Immunization DOSE Was Given				
Diphtheria, Tetanus with Pertussis ☐Td ☐TdaP	1	2	3	4	5
Hepatitis B	1	2	3		
Measles-Mumps-Rubella (MMR)	1	2	Rubella Serology/Date/Titer Mumps disease diagnosed by a physician: Date Measles Serology/Date/Titer		
Varicella☐ Vaccine☐ Disease ☐ Serology Date: Neg/Pos	1	2			
Influenza	1	2	3		

III. TUBERCULOSIS SKIN TEST RESULTS (Testing required per Regulations of the Department of Health)

DATE GIVEN	SITE: LA / RA	GIVEN BY:	ANTIGEN NAME	MANUFACTURER / LOT # / EXP DATE	SIGNATURE
DATE READ	RESULTS in MM		READ BY SIGNATURE		

OR

IGRA TEST RESULTS

DATE COLLECTED	TEST NAME (QFT-GIT, T-SPOT, etc)	POSITIVE	NEGATIVE	INDETERMINATE	QUANTITATIVE RESULT

DATE TEST COMPLETED _____ **SIGNATURE** _____

Previously known/new positive reactors: _____

Chest X-ray: Date: Results:
(Attach a copy of the report.)

Other: Date: Results:
(Attach a copy of the report.)

Preventive Anti-Tuberculosis Chemotherapy ordered: ☐ No ☐ Yes Date: _____

IF SIGNIFICANT REACTION WAS REPORTED, THE PRIMARY CARE PROVIDER REPORT MUST STATE THAT THE APPLICANT IS CURRENTLY FREE FROM TUBERCULOSIS DISEASE.

IV. MEDICAL CONDITIONS (✓)

	Yes	No	If Yes, Explain:
Allergies	☐	☐	
Asthma	☐	☐	
Cardiac	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder	☐	☐	
Hypertension	☐	☐	
Neuromuscular Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder	☐	☐	
Other (Specify)	☐	☐	

V. PHYSICAL EXAMINATION (✓)

	NORMAL	ABNORMAL	NOT EXAMINED	COMMENTS
Height (inches)				
Weight (pounds)				
Pulse				
Blood Pressure				
Hair/Scalp				
Skin				
Eyes – Visual Acuity: RL				
Eyes – Color Vision				
Ears – Hearing (dB) RL				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart – Murmur, etc…				
Lungs – Adventious Findings				

Last Name First MI

Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				

Are there any special medical problems or chronic diseases which require restriction of activity, medication which might affect his/her work role? If so, specify

Are there any special equipment or accommodations needed to enable this person to perform their duties? If so, specify

Physician Name (Print) Signature of Examiner Date

Physician Address

The statements and answers as recorded above are full, complete and true to the best of my knowledge and belief. I understand that any false or misleading statements may cause termination of my employment.

I authorize the physician or other person to disclose any knowledge or information pertaining to my health to the employing authority for whom this examination is performed.

Signature of Employee Date