

### Pre-Employment Physical Form

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Allergies \_\_\_\_\_

**History and Physical Exam (Required): \*Must be within the past 12 months\***

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
 Vision (R) \_\_\_\_\_ (L) \_\_\_\_\_ Both \_\_\_\_\_ Hearing (R) \_\_\_\_\_ (L) \_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	COMMENTS
1. Eyes			
2. Ears/Nose/Throat			
3. Mouth and Teeth			
4. Neck			
5. Heart			
6. Lungs			
7. Abdomen			
8. Skin			
9. Genitals-Hernia			
10. Extremities			
11. Musculoskeletal			
12. Neurologic			

Are there any reason(s) to preclude this person from working in a school with children? Explain.

Tuberculosis Exam (Required): \*Must be within the past 6 months\*

PPD Placed \_\_\_\_\_ Read \_\_\_\_\_ Results \_\_\_\_\_ Chest X-Ray \_\_\_\_\_

**Immunizations (Recommended)**

Hepatitis B Vaccination: Vaccinations given: \_\_\_\_\_

Varicella: Date of illness/immunization: \_\_\_\_\_

MMR: Date of illness/immunization: \_\_\_\_\_ TD Booster: \_\_\_\_\_

I have examined \_\_\_\_\_ on \_\_\_\_\_ and found him/her to be in good health and pose no health risk to others at LEAP Academy.

Health Care Provider's Comments:

Health Care Provider Signature: \_\_\_\_\_

Health Care Provider Name: \_\_\_\_\_

Health Care Provider Address: \_\_\_\_\_

Health Care Provider Phone #: \_\_\_\_\_