RAMAH NAVAJO SCHOOL BOARD, INC.

CERTIFICATE OF EXAMINATION

Name:	Occupation:
School:	Date of Birth:

Results of tests for tuberculosis:

A. Skin Test (only matoux acceptable-millimeter) reading: _____ ("Positive" or "Negative" not acceptable)

B. Chest x-ray (check one)

1. Suggestive of active tuberculosis ( )
2. Suggestive of inactive, adult type tuberculosis ( )
3. Suggestive of lung disease other than tuberculosis ( )
4. Normal chest x-ray ( )

I certify that the above named person is free from tuberculosis in a transmissible form, as of the date indicated below.

The following is applicable only for tuberculin reactors under the age of 35 who are free of adult-type tuberculosis:

_____ I recommend that this person accept isoniazid prophylaxis, using _____ mg daily for one year.

_____ I do not recommend that this person accept isoniazid prophylaxis.

Date

Signature

Physician's Name (type or print)

CERTIFICATE OF REGISTRATION

To be completed by a physician of the health facility;

I hereby certify that the person named on the Certificate of Examination, has registered with the Tuberculosis Control Program of this office.

Date

Signature

Signer's Name (type or print)

Signer's Position-Health Facility

Revised: 11/15/01

RAMAH NAVAJO SCHOOL BOARD, INC.

PHYSICAL EXAMINATION

NAME (Last, First, Middle)	Date of Birth	Sex
Address	Social Security Number	Position or Title

HEALTH INFORMATION

Has Employee: (circle one)

1 Within the past five years have you consulted any doctors, therapists, counselors, or Health care providers for any treatment? Yes No

2. Ever had or been treated of any of the following?

(Please circle)

High Blood Pressure	Yes	No	Bone, joint, muscle disorder	Yes	No
Cancer or Tumors	Yes	No	Paralysis, stroke, epilepsy	Yes	No
Rheumatic Fever	Yes	No	Diabetes, albumin or sugar in urine	Yes	No
Nervous Disorder	Yes	No	Mental Disease, retardation	Yes	No
Heart Disease	Yes	No	Stomach, intestine, liver disorder	Yes	No
Blood Disorder	Yes	No	Eyes, ears or nasal disorder	Yes	No
Heart Murmur	Yes	No	Kidney, bladder, gall bladder disorder	Yes	No
Lung Disorder	Yes	No	Back disorder	Yes	No
Heart Attack	Yes	No	Alcoholism, drug habits	Yes	No

If your answer is "Yes" to one or more of the above questions, explain fully in this space.

Do you have any medical disorder or physical impairment which would interfere in anyway with the full performance of your job?

I certify that all the information given by me in connection with this examination is correct to the best of my knowledge and belief.

Signature of Applicant

TO BE COMPLETED BY EXAMINING PHYSICIAN

RECOMMENDATIONS (Further specialist examinations and follow-up indicated. Specify.)

Examining Physician's Name (type or print)	Signature of Examining Physician
Address	Date of Examination

(IMPORTANT: After signing, return the entire form intact in the pre-addressed "confidential" envelope which the person you examined provided you.

Revised: 08/08/01