GRUNDY COUNTY SCHOOLS
Employee Information and Medical History

Employee _____ **Initial Date of Employment** _____

To be completed by the employee prior to the physician's examination:

Do you have or have you ever had:

	Yes	No		Yes	No
Diabetes			Vision Problem		
Tuberculosis			Hearing Problem		
Heart Disease			Asthma		
High Blood Pressure			Dizziness or Fainting Spells		
Back Injury			Convulsions or Epilepsy		
Head Injury			Nervous/Mental Disorder		

Comments:

Have you been in the hospital within the past two (2) years? _____
If yes, explain: _____

Have you ever been compensated for an occupational injury or disability? _____
If yes, explain: _____

Do you have any condition that would prevent you from performing the essential functions of the job for which you have been employed? _____ If yes, explain: _____
_____

I, the undersigned, do hereby certify that to the best of my knowledge, the answers provided are true; that I have no physical or mental problems, except as listed above, that would prevent me from performing the essential functions for the job for which I have been employed; and that I will openly discuss any existing physical and mental conditions I have with the examining physician.

I understand that any intentional omissions or falsification of answers, either provided above or verbally, may result in termination of my employment.

Employee's Signature: _____

Social Security Number: _____

Date: _____

All new employees (including employees who transfer from one job to another with significantly different work responsibilities) are required to have a physical examination. If possible, this examination should be completed prior to the employee reporting to work for the first time. This form must be completed by both the employee and the physician; the completed form must be returned to the Office of Human Resources not later than sixty (60) days after the initial employment date provided above. Failure to comply may result in termination of employment.

Examiner's Confidential Report – Physical Examination

Employee's Name _____

Social Security Number _____ **Date of Birth** _____

Height _____ **Weight** _____

General Appearance: Good _____ Fair _____ Poor _____

Vision: Right Eye _____ Left Eye _____
Corrective lenses required? Yes _____ No _____

Hearing: Right Ear _____ Left Ear _____

Heart Rate: _____ **Blood Pressure:** Systolic _____
Diastolic _____

List all medications the employee is currently taking: _____
_____
_____

Indications of mental or nervous disabilities: _____
_____

Comments on abnormal findings: _____
_____
_____

I certify that I have examined (name) _____. I have reviewed the available medical record(s) and the physical requirements listed on the attached job description. *I have determined that he/she*

___ is able or ___ is not able

to perform the essential functions of the job for which he/she has been employed.

_____ _____
Physician's Signature Date

_____
Name of Licensed Physician

_____
Business Address

_____
City State Zip Code

_____
Telephone Number