

VALLEY VIEW PUBLIC SCHOOLS – Community Unit District No. 365-U

**Physical Examination**

**Employee Information**

<i>Last Name</i>	<i>First Name</i>	<i>Middle Name</i>
<i>Street Address</i>	<i>City, State</i>	<i>ZIP Code</i>
Date of Birth _____	Age _____	Sex _____ Marital Status _____
Occupation _____	Building Assigned _____	Start date _____

**Family History** – Please indicate if immediate family has had any of the following:

<i>CONDITION</i>	<i>YES</i>	<i>NO</i>	<i>CONDITION</i>	<i>YES</i>	<i>NO</i>
Heart Disease			Tuberculosis		
Diabetes			Epilepsy		
High Blood Pressure			Rheumatic Fever		
Cancer					

**General Physical** – this section to be completed by Physician

Vision: Right 20/\_\_\_\_ Left 20/\_\_\_\_ Color blindness: Passed \_\_\_\_\_ Failed \_\_\_\_\_ Height \_\_\_\_\_  
 Weight \_\_\_\_\_ Hearing: Right \_\_\_\_\_ Left \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

<i>NOR</i>	<i>ABN</i>	<i>Please Mark Each Item (X)</i>	<i>NOR</i>	<i>ABN</i>	<i>Please Mark Each Item (X)</i>
		1. Head, Neck			9. Upper Extremities
		2. Eyes (lids, reflexes, EOM)			10. Lower Extremities, feet
		3. Ears (canals, ducts)			11. Spine
		4. Nose, sinuses			12. Skin/Infections
		5. Mouth, dental condition			13. Reflexes
		6. chest, lungs, breasts			14. Emotional
		7. Heart (rhythm, murmurs, size)			15. Pelvic Exam/Rectal
		8. Abdomen (incl. Hernia)			

Please give details of any abnormalities from above. Indicate pertinent history, surgery, severe accidents or diseases:

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Please indicate if employee should be excluded from any specific type of work de to physical condition

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Tuberculosis Report \_\_\_\_\_ Date \_\_\_\_\_

*I hereby certify that I have examined the applicant named above, and that this is a complete and accurate record of such examination.*

Date of Examination \_\_\_\_\_ Signature \_\_\_\_\_ M.D.

*Name (Please Print)*

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*Street Address* \_\_\_\_\_ *City, State* \_\_\_\_\_ *ZIP Code* \_\_\_\_\_