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DEARBORN SCHOOLS

EMPLOYEE HEALTH RECORD

Name_____ Date of Birth___/___/___ Sex M/F
First Middle Initial Last

Position_____ Building_____

Address_____
Number and Street State Zip

Family Physician_____ Address_____
Number and Street State Zip

Past History – Have you ever had any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
___	___	Epilepsy	___	___	Pleurisy	___	___	Dizziness	___	___	High Blood Pressure
___	___	Pneumonia	___	___	Hay Fever	___	___	Ear Discharge	___	___	Low Blood Pressure
___	___	Hernia (Rupture)	___	___	Tuberculosis	___	___	Asthma	___	___	Fainting
___	___	Jaundice	___	___	Sinusitis	___	___	Typhoid Fever	___	___	Rheumatic Fever
___	___	Heart Disease	___	___	Bronchitis	___	___	Rheumatism	___	___	Eye Disease
___	___	Varicose Veins	___	___	Anemia	___	___	Diabetes	___	___	Frequent Headaches
___	___	Arthritis	___	___	Convulsions	___	___	Tumors	___	___	Kidney Disease
___	___	Stomach Trouble	___	___	Hives	___	___	Eczema	___	___	Frequent Sore Throat

Have you recently experienced what you consider unusual or excessive symptoms such as:

Yes	No		Yes	No		Yes	No		Yes	No	
___	___	Indigestion	___	___	Vomiting Blood	___	___	Lung Trouble	___	___	Pain or Cramps
___	___	Nervousness	___	___	Persistent Lumps	___	___	Blood in Urine	___	___	Nausea or Vomiting
___	___	Palpitation	___	___	Chest Pains	___	___	Insomnia	___	___	Urinary Difficulty
___	___	Persistent Sores	___	___	Cough	___	___	Blood Spitting	___	___	Frequent Fractures
___	___	Back Problems	___	___	Poor Hearing	___	___	Visual Disorders	___	___	Change in Bowel Action
___	___	Loss or Gain in Weight				___	___	Shortness of Breath			

Have you ever had any serious illness not listed above? ___Yes____No
Explain:_____

Do you take any medicine regularly?____Yes____No What Kind?_____

List Accidents:_____

Injuries to Back:_____

Operations: Date of each & Resulting Disability – If None so State:_____

Have you had any illness or consulted a physician in the past year?____Yes____No
Explain:_____

To the best of my knowledge the statements above are correct and may become part of my medical file and used to whatever extent necessary in connection with my employment by Dearborn Public Schools.

Signature_____ Date_____

NOTE: All Dearborn School employees must have on file a satisfactory health record, unless the requirement is waived for temporary work. The examination is to be secured from a private physician and paid for by the applicant. We urge that it be done by your regular family physician. A re-examination may be requested whenever it is deemed necessary. This record becomes part of the employee's cumulative record and is kept strictly confidential.

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To be filled in by the examining physician after examination and review of history.

Name of applicant or employee_____Date_____

I hereby certify that I have examined the above named applicant and findings are as follows:

1. Does applicant have standard vision, with or without glasses?_____

   Color Blindness?_____

2. Is hearing in both ears sufficiently keen for position?_____

***** 3. TUBERCULIN SKIN TEST OR CHEST X-RAY GIVEN____. RESULTS: Negative___Positive___

4. Does health history and examination, including urinalysis, reveal:

   a) Any serious condition, e.g. epilepsy – fainting – diabetes – allergies – heart disease?

      If so, is condition properly controlled?_____

      _____

   b) Any conditions which would be likely to cause frequent absence from work?_____

      _____

   c) Any physical, mental or neurological conditions which would be likely to detract from applicant's ability to serve successfully in the above position?_____

      _____

   d) Ability to do heavy lifting?_____If no, why not?_____

      _____

5. In my opinion, the person examined is:

   _____Physically fit for employment in the indicated position without limitations.

   _____Not physically fit for employment without limitations for the following reasons:_____

   _____

   _____

Remarks and Recommendations to school:

Signed_____M.D. or D.O. Examining Physician

***** A negative chest x-ray report from the County Health Department, dated within three months, is acceptable in lieu of the physician's answer to this question.