KENTUCKY DEPARTMENT OF EDUCATION
MEDICAL EXAMINATION OF SCHOOL EMPLOYEES*

Name ________________________________ **Date of Birth** ____/____/____ **Sex:** **M** ☐ **F** ☐

Address ________________________________ **Telephone** ________________

Applicant With or Employed By ________________________________ **Board of Education**

HISTORY

Medical (All serious medical and psychiatric diseases: diabetes, epilepsy, heart disease, etc.) ________________

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Surgical (All major operations) ________________________________

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"Per the Genetic Information Nondiscrimination Act of 2008, it is unlawful for an employer to request genetic information, genetic testing information, family medical history information, or family genetic testing information from an applicant or employee. The medical provider conducting this examination of an applicant/employee of a local school district shall not request, require or purchase this information about the applicant or employee. Any applicant or employee undergoing a medical examination for employment with a local school district shall not provide this information to the medical provider or the school district."

PHYSICAL

1. General Appearance ________________
2 Eyes ________________
3. Ears, Nose & Throat ________________
4. Teeth & Gums ________________
5. Thyroid ________________
6. Heart ________________
7. Blood Pressure __________ Pulse __________
8. Lungs ________________
9. Abdomen ________________
10. Nervous System ________________
11. Extremities ________________

Other ________________

Tuberculosis Risk Factor Assessment

Yes ☐ No ☐ High risk for Tuberculosis infection

Yes ☐ No ☐ Referred to local health department for further TB infection evaluation

Yes ☐ No ☐ Tuberculosis test performed (specify: _________TST/_________BAMT)

________________________Date of chest X-Ray

☐ No further follow-up unless signs/symptoms of Tuberculosis infection develop

I have examined ________________________ and find him/her free of communicable disease and any physical or mental disabilities that might interfere with performing his/her duties, except as follows:

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________________________ Date of Examination

________________________ Signature (Physician/PA/APRN)

* School Bus Drivers are required to use form TC94-35E.