VESTAL CENTRAL SCHOOL DISTRICT
Vestal, New York 13850

PHYSICAL EXAMINATION

AN EXAMINATION OF:

NAME_____

BLOOD PRESSURE _____/_____ HEIGHT _____ WEIGHT _____ TEMPERATURE _____

PAST MEDICAL HISTORY

A. MEDICAL PROCEDURES (LIST): _____

_____

B. SURGERIES (LIST): _____

_____

MEDICATIONS (WITH DOSAGE) _____

_____

ALLERGIES _____

SMOKE: NO ____ YES ____ AMOUNT _____ / ALCOHOL _____ AMOUNT _____

FAMILY HISTORY _____

SOCIAL HISTORY _____

REVIEW OF SYSTEMS	NORMAL	ABNORMAL	IF ABNORMAL, EXPLAIN
GENERAL			
EYES (INCLUDE VISION)			
EARS			
NOSE			
MOUTH			
NECK (THYROID, ETC.)			
BACK			
LUNGS			
CARDIOVASCULAR			
ABDOMEN			
MUSCULO-SKELETAL			
CUTANEOUS			
EXTREMITIES			
NEUROLOGICAL			
OTHER			

IN MY OPINION, THE ABOVE PATIENT IS ABLE TO PERFORM THE DUTIES REQUIRED OF THE INDIVIDUAL BY THE VESTAL CENTRAL SCHOOL DISTRICT. NO ____ YES ____

CONCLUSIONS BASED ON THE ABOVE: _____

_____

RECOMMENDATIONS: _____

_____

_____ _____

DOCTOR'S SIGNATURE DATE

TO EMPLOYEE: PLEASE SIGN BELOW. YOUR SIGNATURE ALLOWS YOUR PHYSICIAN TO SEND A COPY OF THIS PHYSICAL TO THE DISTRICT SUPERINTENDENT.

_____ _____

EMPLOYEE SIGNATURE DATE