MONTAGUE TOWNSHIP SCHOOL DISTRICT

475 Route 206 Montague, NJ 07827
V: 973 293 7131 / F: 973 293 3391
www.montagueschool.org

EMPLOYEE HEALTH RECORD

Name: _____ Address: _____

Position: _____ Age: _____ Date of birth: _____

Vaccination History/Communicable Disease

Have you had:	Yes	No	Unsure
The standard series of your childhood vaccinations (to the best of your knowledge)?			
The disease "chicken pox" or the chicken pox vaccine (varicella)?			
A tetanus/diptheria booster shot within the last 10 years?			
The disease "Tuberculosis"?			
A positive tuberculosis test (also called a PPD or Tine test)?			

Current Medical Conditions Those that you are currently experiencing and/or receiving treatment for (such as diabetes, migraines)

Please list	Date of onset (mo/yr)	Please List	Date of onset (mo/yr)
1)		3)	
2)		4)	

Past Medical Conditions Those that you have had in the past but have recovered from (such as childhood asthma)

Please list	Date of onset (mo/yr)	Please list	Date of onset (mo/yr)
1)		3)	
2)		4)	

Surgeries/Hospitalizations List type of surgery (ex: gall bladder) or condition for which you were hospitalized (ex: heart attack)

Please list	Date of onset (mo/yr)	Please list	Date of onset (mo/yr)
1)		3)	
2)		4)	

Medications: Please include non-prescription medications, vitamins and herbal supplements in addition to prescription medications

Please list	Date of onset (mo/yr)	Please list	Date of onset (mo/yr)
1)		3)	
2)		4)	

I certify the above answers to be true _____ _____

Employee's Signature Date

PHYSICAL EXAMINATION

Height	Weight	BMI	Blood Pressure	Pulse	Respirations	Temperature
Vision:	Uncorrected/Corrected (circle): OD-____/____OS-____/____OU-____/____					

Assessment/Remarks: _____

		Normal	Abnormal	Note: Please describe abnormality with pertinent numeral before comment
1	General Appearance			
2	Skin			
3	Head			
4	Eyes			
5	Ears			
6	Nose			
7	Teeth			
8	Mouth/Throat			
9	Neck/Thyroid			
10	Lymphatics			
11	Breast			
12	Heart			
13	Lungs			
14	Abdomen			
15	Hernia			
16	Spine & Back			
17	Nervous System			
18	Extremities/Feet			

_____

_____

Date of last Mantoux: _____ Result: _____

Date of last Tetanus Booster: _____

Date of Hepatitis B vaccine: #1_____ #2_____ #3_____

Printed Name of Physician: _____

Address of Physician:_____

Physician Signature: _____ Date:_____