

POINT PLEASANT SCHOOLS

Superintendent's Office

2100 Panther Path

Point Pleasant, New Jersey 08742

732-701-1900 Ext. 2412 Fax: 732-892-8403

Certificate of Health

All candidates for employment are required by Education Law Title 18A:16-2 to undergo a physical examination and report results to the Board of Education. This form shall be completed in its entirety and returned to the Office of the Superintendent of Schools.

To be completed by applicant:

Name: _____ Last Physical Exam Date: _____

Date of Birth: _____ Phone #: _____

Home Address: _____

Position Offered: _____

Personal Medical History (check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Headaches, migraines |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Seasonal allergies |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Cough | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Lung disease (COPD, emphysema) | <input type="checkbox"/> Hernia | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Backaches (herniated disk, neck pain) | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Depression, anxiety | <input type="checkbox"/> Change in bowel habits | <input type="checkbox"/> Alcoholism or other addiction |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Gall bladder disorder - Gallstones | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> I have none of the above medical conditions. | | |

Comments: _____

Check if history of childhood diseases:

- | | | | |
|--------------------------------------|----------------------------------|---|--------------------------------|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles | <input type="checkbox"/> German Measles | <input type="checkbox"/> Mumps |
|--------------------------------------|----------------------------------|---|--------------------------------|

Family History (check all that apply):

- | | | |
|---|--|---------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | | |
| <input type="checkbox"/> None of the above medical conditions | | |

Medications:

List all prescription medications below: _____

List all over the counter medications: _____

List allergies to medications: _____

Type of reaction: _____

Hospitalizations:

Illnesses – List date/type: _____

Surgeries – List date/type: _____

Any other serious accidents – List date/type: _____

Work Injuries

Have you ever been hurt on the job? Yes No

If yes, describe the type/location of the injury: _____

The date of the injury: _____

The duration of treatment: _____

Name and address of the treating physician: _____

Have you ever been refused employment or insurance because of ill health?

Yes No If yes, explain: _____

I hereby certify that all the information I have furnished is true and correct.

Signature _____ Date _____

Mantoux Test:

Date test administered: _____ Date test read: _____

Result of Mantoux Test: _____

Name of Physician or School Nurse

Signature

Physicians Certification

I hereby certify that I have examined _____ and find that he/she is free from physical/mental conditions that would interfere with successful performance in the position offered.

Name of Physician

Signature

Address: _____

Phone #: _____ Date: _____