

INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS CAREFULLY

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To be completed by Prospective Employee

Page 2

Section A

Visual Screening 10 ft. – 20 ft. (must be within 2 years – can be completed by examining physician. Will accept copy of eyeglasses and contacts prescription as long as it is within 2 years)

Section B

Tuberculin Skin Test (must be within 3 months – Will accept copy of TB Test)

NOTE: Health Services must have the TB Test even if a copy has been provided to Human Resources. Do Not Assume It Was Given To Health Services.

Section C

Immunization History: To be completed by Prospective Employee

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Medical Examination (must be within 3 months)

The examining physician must certified physical examinations older than 3 months, but not more than one year. Physical examinations older than one year will not be accepted.

 **IMPORTANT NOTE** 

**The physical examination form must be signed by the examining physician.
(NO RUBBER STAMP PLEASE)**

**Physical examinations performed by a Physician's Assistant or a Nurse Practitioner must be counter-signed by the Supervising M.D. or D.O.
"No Exceptions"**

If there are questions regarding this form, please call Health Services at 412-622-3940.

Return the **ORIGINAL** completed Health Appraisal Record to the office below. **Do not** turn in a copy, fax or scan. It will be returned. All questions must be answered. Incomplete forms will be returned.

Pittsburgh Public Schools
Health Services, Room 430
341 S. Bellefield Avenue (15213)

The information requested in this Health Appraisal Record is to determine whether you have the physical and mental qualifications necessary to perform the job with or without reasonable accommodation, whether you can perform the job without posing a direct threat to the health and safety of others, and to obtain information in compliance with State Law.

Name _____ Date _____
LAST FIRST MIDDLE

Residence _____
Number & Street City & State ZipCode

Phone No. _____ Sex _____ DOB _____

Specify Position _____ Subject _____ Grade _____

Social Security No. _____

Medical Discharged from Military Service? Yes No N/A

Person to notify in case of emergency _____

Relationship _____ Phone No. _____

Family doctor's name and address _____

To be completed only by the Prospective Employee. Explain all questions answered "YES"

Check "YES" or "NO"

YES NO

Check "YES" or "NO"	YES	NO	
1. Are you now under a physician's care?			
2. Do you take any medication daily, weekly or monthly?			
3. Are you receiving or have you in the past applied for and/or received a disability pension or worker's compensation benefits? If you answer yes, indicate the date, the type of injury or disability, disposition of the claim and dates of receipt of benefits.			

PRINT NAME

Original

HEALTH APPRAISAL SCREENING TESTS

VISUAL SCREENING AT 10 FT. OR 20 FT. DISTANCE

NOTE: MUST BE COMPLETED – NOT AN OPTION

Must be within 2 years prior to the date PPS receives form. Screening can be completed by examining physician. Copy of eyeglasses and contact lenses prescription is acceptable as long as it is within 2 years prior to the date PPS receives information.

Without Glasses	O. D.
	O. S.
With Glasses	O. D.
	O. S.
Contact Lenses	O. D.
	O. S.

Signature & Title of Examiner

Examination Date

Visual defects require screening with and without lenses

IMMUNIZATION HISTORY

To be completed by Prospective Employee: Please check Yes or No. Provide dates if known. If immunizations were received as a child, put "childhood".

	YES	NO	
Tetanus			Date of last booster:
Hepatitis B			Dates:
Measles			Dates:
Mumps			Dates:
Rubella			Dates:
Polio			Dates:

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Original

Original

Date of Examine _____

Name _____ DOB _____

Past Medical History _____

List of Chronic Medications _____

Height _____ Weight _____ BP _____

General Appearance _____

Skin _____ Rashes _____

HEENT _____

Thyroid _____ COR _____

Lungs _____ Abd _____

Genito-Urinary System:

Hernia _____ Rectal _____

Extremities:

ROM _____ Spine _____

Neuro _____

Impression _____

_____ Is medically cleared without limitations for the position of _____

_____ Is medically cleared with these restrictions _____

Anticipated duration of restrictions _____

Physical Examinations older than one year will not be accepted. The examining physician must certify physical examinations older than 3 months, but not over one year. The examining physician's signature certifies this statement: "As of the current date, the individual named above is cleared without limitations for the position indicated".

! The physical examination form must be signed by the examining physician. [NO RUBBER STAMP PLEASE] Physical examinations performed by a Physician's Assistant or Nurse Practitioner must be counter-signed by the Supervising M.D. or D.O. - "No Exceptions" !

Physician Signature _____ Printed Name _____ Date _____

Address of Physician _____

Phone _____ Fax _____

Original

Original

PRINT NAME

TUBERCULIN SKIN TEST

(COPY ACCEPTABLE)

TB Test **MUST be within 3 months** prior to the date PPS receives form as stated in 28 PA Code 23.44(j)

Negative x

IF TEST IS POSITIVE, A CHEST X-RAY IS REQUIRE AND THE X-RAY REPORT MUST BE PROVIDED.

Positive (Record Size) x

Date TB Test Given x

x
Signature & Title of Medical Professional

Date TB Test Read x

x
Signature & Title of Medical Professional

NOTE: The medical professional who administers the test must read results. Results read by the prospective employee are not acceptable.