CHICAGO PUBLIC SCHOOLS

Employee Physical Examination Form

(Please complete in English)

(Revised 04/98)
(Revised 11/98)
(Revised 06/00)
(Revised 02/01)

For Use Only by Chicago Public Schools
EMPLOYEE HEALTH SERVICES

Accepted: _____
Incomplete: _____
_____
Not Accepted: _____
Signature: _____

Employee Health Services
125 South Clark Street
2nd Floor
Chicago, IL 60603
Phone 773/553-1180

- As a condition for employment in the Chicago Public Schools you must **successfully** pass an examination to determine that you are in good health and free of tuberculosis. In addition, **your physician must provide the results of your TB skin test or chest x-ray, as well as the date on which it was performed, and read, within the last 90 days to comply with Illinois School Code.**
- I hereby give consent to have further information that is requested by the Chicago Public Schools Employee Health Services released by the physician who examined me.
- I certify that my responses above are complete and true to the best of my knowledge.

_____ Signature of Employee _____ Date

TO BE COMPLETED BY PHYSICIAN: (PHYSICAL EXAMINATION MUST BE PERFORMED BY A PHYSICIAN LICENSED IN ILLINOIS OR ANY OTHER STATE TO PRACTICE MEDICINE AND SURGERY).

Date of Examination: _____ General Appearance: _____
Height: _____ Weight: _____ Allergies: _____
Temperature: _____ Pulse: _____ Respiration: _____ B/P: _____
TB Test*: Date Done: _____
Date Read: _____ Result: _____ MM
If positive, chest x-ray Date Done: _____ Result: _____ Date TB prophylaxis initiated: _____

*** Illinois School Code requires Chicago Public Schools to screen employment candidates for tuberculosis. A TB skin test must be performed within the last 90 days. The date the TB test was administered, the date the TB test was read and the results must be documented. Self-reading by employee is not acceptable. If the TB test is positive, a chest x-ray must be performed within the last 90 days. The date of the chest x-ray, results and initiation of treatment as necessary must be documented.**

	Normal		
SYSTEM	Yes	No	If abnormal, Comments:
Skin			
Eyes			
Ears			
Nose			
Throat/Dental			
Cardiovascular			
Respiratory			
Gastro Intestinal			
Genito-Urinary			
Neurological			
Musculoskeletal			
Other			

Summary of Findings:

_____

_____

I hereby certify that I have examined the above applicant and that the above is a complete and accurate record of my examination.

I hereby state that this employee is in good physical and mental health which is required to perform the essential functions of the position for which he or she is applying.

Medical License Number: _____
Print Name: _____ M.D./D.O.
Signature: _____
Address: _____
_____
Telephone: _____ Fax: _____

POSITION
EMAIL ADDRESS
PHONE #
SOCIAL SECURITY #
NAME
ADDRESS