BERING STRAIT SCHOOL DISTRICT
P.O. Box 225
Unalakleet, Alaska 99684

MEDICAL EXAM FORM

Part I: **Medical History:** (To be completed by Examinee)

NAME:_____BIRTHDATE _____

SCHOOL:_____POSITION _____

A. Do you have any impairment of:
Hearing? Yes ____ No____ Breathing? Yes ____ No____
Vision? Yes ____ No____ If yes, do you wear glasses? Yes ____ No ____

B. Do you have:
Severe recurrent headaches? Yes ____ No ____
Chronic colds or sore throats? Yes ____ No ____
A thyroid disorder? Yes ____ No ____
A heart condition or abnormal blood pressure? Yes ____ No ____
A respiratory problem including asthma, and/or tuberculosis? Yes ____ No ____
A digestive problem including an ulcer, gallbladder condition, colitis, or hemorrhoids? Yes ____ No ____
Arthritis? Yes ____ No ____
Excessive fatigue? Yes ____ No ____
Any other medical condition which would affect your capacity to perform your work? Yes____ No ____

Explain:_____

_____

_____

C. Have you had any illness or injury which has left you with residual disability? Yes ____ No ____
D. Have you any major allergies? Yes ____ No ____
E. Please list any important operations you have had.

Date:	Nature of Operation:
_____	_____
_____	_____
_____	_____
_____	_____

F. Immunizations:

Diptheria:	Date: _____
Tetanus:	Date: _____
Typhoid:	Date: _____
Smallpox:	Date: _____
Polio:	Date: _____
Measles:	Date: _____

The information above is complete and true to the best of my knowledge. I authorize release of the above information and the physical examination findings to the Bering Strait School District and the Alaska Department of Education.

Part II. Medical Examination (To be completed by Doctor)

A. GENERAL
Height: _____Weight: _____Pulse:_____ Blood Pressure: _____

**Doctor: If condition is satisfactory for intended employment, signify by checking each item. If unsatisfactory, please specify at end of section.

Ears	____	Heart	____	Eyes	____
Lungs	____	Nose & Sinuses	____	Abdomen	____
Mouth & Teeth	____	Hernia	____	Throat	____
Back	____	Neck	____	Extremities	____
Chest-Breasts	____	Skin	____	Psychiatric	____

Abnormalities:

_____

_____

B. LABORATORY STUDIES

Urinalysis: Date: _____ Within Normal Limits _____ Abnormal_____
If abnormal, specify:_____

C. IMMUNIZATIONS: (If administered)

Diptheria:	Date _____	Smallpox:	Date _____
Measles:	Date _____	Polio:	Date _____
Tetanus:	Date _____	Typhoid:	Date _____

DOCTOR'S CERTIFICATION

Applicant/Employee's Name:_____

I have examined the above named applicant/employee and:

( ) 1. Declare him/her physically and mentally ready for employment.
( ) 2. Declare him/her unfit for employment on the basis of a physical and/or mental deficiency.
( ) 3. Recommend the applicant have a follow-up examination as indicated:
_____
( ) 4. Recommend the following procedures before approval can be given:
_____

Date of Examination: _____ _____
Physician Signature

Name and Address of Physician:

_____
_____
_____