



REPORT OF PHYSICAL EXAMINATION

LOCKPORT AREA SPECIAL EDUCATION COOPERATIVE

NAME: _____
(LAST) (FIRST) (MIDDLE INITIAL)

ADDRESS: _____

POSITION APPLIED FOR: _____

- GENERAL PHYSICAL CONDITION _____
- SKIN _____
- VISION _____
- HEART _____
- HEARING _____
- NOSE AND THROAT _____
- RESPIRATORY SYSTEM _____

Any known or suspected tuberculosis in home? Yes No

Tuberculin Test _____ Date given _____
(must be within last 30 days)

Negative Positive If positive, was x-ray taken? Yes No

Result of x-ray _____

- URINALYSIS _____ ALBUMEN _____ SUGAR _____ BLOOD _____
- SUMMARY OF DEFECTS _____

(Please use reverse side if more space is needed.)

I hereby certify that I have examined the above applicant and that the above is a complete and accurate record of such examination. Further, in my opinion, the above applicant is capable of performing the duties of the position for which she/he has applied.

Physician Signature Date

Physician Name _____

Address _____

Phone _____