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STAFF MEDICAL

GENERAL INFORMATION

(To be completed by employee)

NAME: _____

ADDRESS:

PHONE No.: _____ **SEX:** _____ **D.O.B.** _____

PHYSICAL EXAMINATION

(To be completed by a licensed physician)

This individual has been hired for a position with LIVINGWATERS HEALTH CARE, which will entail working with seniors, developmentally, physically, and mentally challenged individuals. In the course of your examination, please note any medical problems of which we should be aware.

GENERAL ASSESSMENT:

Is the individual physically fit for his/her duties that may require physical exertion?

	Yes	No
Cardiovascular	()	()
Musculoskeletal	()	()
Sensory (vision/hearing)	()	()
Other systems	()	()

Are there any conditions restricting the physical ability to work:

IMMUNIZATIONS:

Is this individual fully immunized?

- | | | |
|--------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> POLIO | <input type="checkbox"/> TETANUS | <input type="checkbox"/> MEASLES |
| <input type="checkbox"/> MUMPS | <input type="checkbox"/> RUBELLA | <input type="checkbox"/> TB |

DATE OF MOST RECENT BOOSTER:

ALLERGIES:

Is this individual allergic/sensitive to any of the following?

- | | | |
|-------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> PENICILLIN | <input type="checkbox"/> INSECT STINGS | <input type="checkbox"/> OTHER DRUGS |
| <input type="checkbox"/> FOODS | <input type="checkbox"/> ANIMALS | <input type="checkbox"/> OTHER |

Specify:

This is to certify that I examined _____ and reviewed his/her laboratory test results. I have found him/her not a carrier of Hepatitis B, free from active tuberculosis, and free from other communicable and contagious disease. I believe he/she is fit to undertake his/her duties associated with his/her position with LIVINGWATERS HEALTH CARE.

DOCTOR'S SIGNATURE:

DATE:

PLEASE TYPE OR PRINT CLEARLY THE FOLLOWING INFORMATION:

DOCTOR'S NAME

ADDRESS:

PHONE No.:
