# MEDICAL EXAMINATION REPORT

**THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS.**

## PAYMENT FOR SERVICES RENDERED IS THE RESPONSIBILITY OF THE INDIVIDUAL

**INSTRUCTIONS:**
**To be completed by a qualified medical professional (Physician, Physician's Assistant, or Nurse Practitioner licensed to practice medicine in North Carolina, or Physician and/or Surgeon authorized to practice medicine in accordance with the rules and regulations of the U.S. Armed Forces, [12 NCAC 9B .0104(a)], following an actual physical examination. The original or a copy of this report must be retained in personnel files by the school director.**

DATE: _____ SOCIAL SECURITY #_____-_____-_____

NAME: _____ DATE OF BIRTH _____
Last First Middle

EMPLOYING AGENCY: _____

Height: _____ _Weight: _____

**VISION**

Visual Acuity: **If applicant wears glasses or contacts, test and record acuity with and without glasses**

Without glasses: R - 20 / _____ L- 20 / _____ Both - 20 / _____

With glasses: R - 20 / _____ L- 20 / _____ Both - 20 / _____

Color Perception: " Normal " Abnormal: _____

Peripheral Vision: " Normal " Abnormal: _____

**HEARING**

Hearing Acuity: " - Audiogram - or - " 15' whispered conversation (check one)

Right ear: " - Normal " - Abnormal: _____

Left Ear: " - Normal " - Abnormal: _____

**(Continued)**

**CARDIOVASCULAR**

Blood Pressure: _____ Resting Pulse: _____

Cardiac Examination: □ - Normal □ - Abnormal: _____

Peripheral Circulation: □ - Normal □ - Abnormal: _____

ECG: □ - Indicated by hx or exam: _____ (If resting pulse is less than 50 or greater than 100)

ABNORMAL FINDINGS
HEENT: _____
LUNGS: _____
ABDOMEN: _____
MUSCULOSKELETAL: _____
GENITOURINARY: _____
NEUROLOGICAL: _____
SKIN: _____

URINALYSIS □ - Normal □ - Abnormal: _____
TB SKIN TEST Millimeters of Induration _____

**Are there any conditions, physical, emotional or mental, which, in your opinion, suggest further examination?**
□ - No □ - Yes:

_____
_____
_____
_____

**Do you have any reservations about this candidate=s ability to physically perform required duties?**
□ - No □ - Yes:

_____
_____
_____
_____
_____
_____
_____

_____
Signature of Qualified Medical Professional

_____
Date

Name and Address of Qualified Medical Professional
**PLEASE TYPE**