CENTRAL MONTCO TECHNICAL HIGH SCHOOL
ALLIED HEALTH

THIS SECTION TO BE COMPLETED BY THE STUDENT / PARENT / GUARDIAN	
Name of Individual Examined	
Name of Requester Central Montco Technical High School	Requester's Telephone No. 610-277-2301
Requester's Address 821 Plymouth Rd., Plymouth Meeting, PA 19462	
Purpose of Examination ☐ Initial Enrollment ☐ Annual Re-Exam	Type of Activity (check all applicable) ☑ Stand for long periods ☑ Carry, push, pull at least 49 lbs. ☑ Transfer and transport patients ☑ Assist with patient ADL's

PART 1 – As shown by physical examination, does the individual have:	YES	NO		YES	NO
1. At least 20/40 combined visions, corrected by glasses, if needed?			5. Normal respiratory system?		
2. Normal hearing?			6. Normal skin?		
3. Normal blood pressure?			7. Normal neuro-muscular system?		
4. Normal cardiovascular system?			8. Normal endocrine system?		

EXPLAIN ALL "NO" RESPONSES ON REVERSE OF FORM GIVING PLAN FOR FOLLOW-UP

PART 11 – Does this individual have any of the following medical problems:	YES	NO		YES	NO
9. History of myocardial infarction, angina pectoris, coronary insufficiency?			13. Inadequate immune status (Td, measles, mumps, rubella)?		
10. History of epilepsy"			14. Need for more sick days than average for age?		
11. Diabetes?			15. Current drug or alcohol dependency?		
12. Thyroid or other metabolic disorder?			16. Disabling emotional disorder?		

17. Other special medical problem or chronic disease which required restriction of activity, medication or which might affect his/her work role? If so, specify on reverse of form.

PART 111 – Required test for Tuberculosis: Intracutaneous Mantoux two step method

TWO-STEP Intracutaneous Mantoux Test Method **REQUIRED BY STATE**	Report of First Test	Report of Second Test Non-significant on First Test 1 to 3 weeks later
Name of antigen used and manufacturer		
Lot number		
Dose of purified protein derivative		
Date on which test was applied		
Date on which test read		
Measurement of widest diameter of induration of millimeters		

If Positive:

Date of Report of 14 x 17 chest x-ray (attach a copy of report)

PART IV – IMMUNIZATIONS

Hepatitis B	Dose 1	Date
Hepatitis B	Dose 2	Date
Hepatitis B	Dose 3	Date
Current Flu vaccine	Lot #	Date

_____ _____
Physician Signature Physician Name (print)

_____ _____
Physician Address Date

Patient Authorization
The statement and answers as recorded above are full, complete and true to the best of my knowledge and belief. Unless prohibited by law I authorize the physician or other person to disclose any knowledge or information pertaining to my health. I understand that any lie or misleading statements may cause termination of my employment.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature Date