HEALTH EXAMINATION CERTIFICATE **North Carolina Public Schools**

Required of all persons upon initial employment, separation from employment more than one school year, absence of more than 40 successive days because of a communicable disease, or when deemed necessary by a local school board or superintendent. (Ref. NCGS 115C-323)

Name:_________________________________ Social Security Number:_______________
Address:____
____

The above named individual is to be recommended for employment by _______________________ (local school board) in a position of _______________________ . In this position, the condition of certain physical capacities will be of importance. Please examine the areas listed below and report any limitations, deficiencies or related restrictions.

I. Communicable Disease

By my signature I certify that the above **named person does not have any communicable disease, including tuberculosis**, that poses a significant risk of transmission in our schools or would impair this person's ability to perform the duties of the job, except as may be noted below. Further, I certify that this person is free of any physical or mental disability that would impair job performance.

If unable to certify the above, please comment:

____

____

II. Other Health Areas

AREAS	LIMITATIONS YES	NO	NATURE OF LIMITATIONS (continue on back as needed)
Vision			
Hearing			
Heart			
Lungs			
Lifting/Carrying			

Appropriate Immunizations	Current? YES	NO	Any Immunization Recommendations
Td (tetanus),Hep B, MMR, etc.			

Date: ____________ _______________________________________
Physician, Physician's Assistant, or Nurse Practitioner (Type or Print)

SIGNATURE: _______________________________________

License/Registration #: ____________ State* Granting License/Registration: ____________

*For initial employment of an out-of-state applicant the certificate may be completed by a health care provider with an out-of-state unrestricted current license or registration.

1/2002

Tuberculosis Risk Questionnaire

Question		
1) Were you born outside the USA in one of the following parts of the world: Africa, Asia, Mexico, Central America, South America, or Eastern Europe?	YES	NO
2) Have you traveled outside the USA and lived for more than one month in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe?	YES	NO
3) Do you have a compromised immune system such as from any of the following conditions: HIV/AIDS, organ or bone marrow transplantation, diabetes, immunosuppressive medicines (e.g. prednisone, Remicade), leukemia, lymphoma, cancer of the head or neck, gastrectomy or jejeunal bypass, end-stage renal disease (on dialysis), or silicosis?	YES	NO
4) Have you ever done one of the following: used crack cocaine, injected illegal drugs, worked or resided in jail or prison, or worked or resided at a homeless shelter?	YES	NO
5) Have you ever been exposed to anyone with infectious tuberculosis?	YES	NO

Tuberculosis Symptom Questionnaire

Do you currently have any of the following symptoms?

1) Unexplained cough lasting more than 3 weeks	YES	NO
2) Unexplained fever lasting more than 3 weeks	YES	NO
3) Night sweats (sweating that leaves the bedclothes and sheets wet)	YES	NO
4) Shortness of breath	YES	NO
5) Chest pain	YES	NO
6) Unintentional weight loss	YES	NO
7) Unexplained fatigue (very tired for no reason)	YES	NO