Teacher & Substitute Teacher Form

Name: _____ Sex: ___ Age: ___ Date of Birth: ___ /___ /___

Address: _____

City: _____ State:_____ Zip Code :_____Phone: (____)_____

Emergency Contact: _____ Phone: (____) _____

Personal/Family Physician: _____ Phone: (____) _____

Medical History

(Explain "yes" answers below. Circle questions you do not know the answer to.)

1. Have you had a medical illness or injury in the last 5 years?	**Yes**	**No**	**17. Have you ever had a head injury or concussion?**	**Yes**	**No**
2. Do you have problems with your eyes, ears, nose or throat?	**Yes**	**No**	**18. Have you ever had a seizure?**	**Yes**	**No**
3. Do you wear corrective lenses?	**Yes**	**No**	**19. Do you have frequent or severe headaches?**	**Yes**	**No**
4. Do you have an ongoing chronic illness?	**Yes**	**No**	**20. Have you ever been knocked out, become unconscious or lost your memory?**	**Yes**	**No**
5. Have you ever been hospitalized overnight?	**Yes**	**No**	**21. Have you had any problems with your eyes or vision?**	**Yes**	**No**
6. Have you ever had surgery?	**Yes**	**No**	**22. Have you ever had a sprain, strain or swelling after injury?**	**Yes**	**No**
7. Are you currently taking any prescription or nonprescription (over-the counter) medications?	**Yes**	**No**	**23. Have you broken or fractured any bones or dislocated any joints?**	**Yes**	**No**
8. Do you have any allergies (i.e. pollen, medicine, food, animals, or stinging insects)?	**Yes**	**No**	**24. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?**	**Yes**	**No**
9. Do you have seasonal allergies that require medical treatment?	**Yes**	**No**	**25. Have you ever had sleep disorders (i.e. pauses in breathing while asleep, daytime sleepiness, loud snoring)?**	**Yes**	**No**
10. Do you have asthma?	**Yes**	**No**	**26. Have you ever had diabetes or elevated blood sugar?**	**Yes**	**No**
11. Do you cough, wheeze or have trouble breathing during or after activity?	**Yes**	**No**	**27. Have you ever had numbness or tingling in your arms, hands, legs or feet?**	**Yes**	**No**
12. Do you have any current skin problems (i.e. itching, rashes, acne, warts, fungus or blisters)?	**Yes**	**No**	**28. Do you frequently consume alcohol?**	**Yes**	**No**
13. Have you ever had racing of your heart or skipped heartbeats?	**Yes**	**No**	**29. Do you use narcotic or habit forming drugs?**		
14. Have you had high blood pressure or high cholesterol?	**Yes**	**No**			
15. Have you ever been told you have a heart murmur?	**Yes**	**No**			
16. Has any family member or relative died of heart problems or sudden death before age 50?	**Yes**	**No**			

Explain 'Yes' Answers here:

_____

_____

_____

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Review of Symptoms

Do You Have Any of the Following?	Yes	No	Do You Have Any of the Following?	Yes	No
Weight loss / Weight gain (circle)			Palpitations or skipped beats		
Fevers			Chest pain or tightness		
Headaches			Indigestion/heartburn		
Difficulty with vision / Wear lenses or glasses			Abdominal pain		
Dizziness / Vertigo			Diarrhea/constipation		
Difficulty hearing			Irregular periods		
Seasonal allergies			Frequent urinary tract infections		
Sinus Problems			Kidney stones		
Tiredness or falling asleep during the day			Back pain		
Unable to tolerate heat or cold			Joint pain or swelling		
Shortness of breath with or without exertion			A history of broken bones		
Wheezing			Swelling of the legs		
Cough			Skin problems (rash, eczema, psoriasis)		

Physical Examination

Name: _____ Date of Birth:__ /__ /__

Height: _____Weight: _____ Pulse: _____

Blood Pressure: _____ / _____ (_____ / _____ , _____ / _____)

Visual Acuity: Right 20/_____ Left 20/ _____ Corrected: Yes | No Pupils: Equal _____Unequal_____

Findings	Normal	Abnormal Findings
MEDICAL		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

Tuberculosis Test Results: Pass _____ Fail _____ Date Checked:_____

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ASSESSMENT OF EXAMINING HEALTHCARE PROVIDER

Sec. 24-5 of the School Code states in part -- "School boards shall require of new employees evidence of physical fitness to perform duties assigned and freedom from communicable disease. Such evidence shall consist of a physical examination by a physician licensed in Illinois or any other state to practice medicine and surgery in all its branches, a licensed advanced practice nurse, or a licensed physician assistant not more than 90 days preceding time of presentation to the board, and the cost of such examination shall rest with the employee."

Tuberculosis tests are required by all employee/substitutes that are in a Pre-K facility.

I hereby certify that_____ meets the above
(Please print)
requirements of physical fitness and freedom from communicable disease.

_____ _____

(Signature, Healthcare Provider) **(Print Name, Healthcare Provider)**

_____ _____

(Substitute's SS# or IEIN#) **(Date)**

_____Date of Physical

_____Date TB test was read/passed