

Southwest Cook County Cooperative
 Association for Special Education
 Phone: (708) 687-0900

CERTIFICATE
OF HEALTH
EXAMINATION

6020 W. 151st Street
 Oak Forest, IL 60452
 Fax: (708) 687-5695

Name: _____ Address: _____

TO BE COMPLETED BY PHYSICIAN

EVALUATION:	Normal	Abnormal	Comments
General Physical Condition			
Height _____ Weight _____			
Skin			
Eyes			
Ears			
Nose			
Throat			
Throat/Dental			
Cardiovascular B/P			
Respiratory			
Gastrointestinal			
Genito-Urinary			
Neurological			
Muscular Skeletal			
Allergies (List):			
Routine Medication(s) (List):			

TESTS

Tetanus (Date of Last Booster): _____

* TB Skin Test or Chest X-Ray (if prev. test older than 12 mos): Date: _____ Results: Positive Negative
 Hepatitis B Immunization: YES NO (Not required for employment)
 If yes, indicate dates of injections: Mo/Day/Yr. Mo/Day/Yr. Mo/Day/Yr.

FINDINGS AND RECOMMENDATIONS

A. Findings: Summary of health problems or conditions, if any, which may affect the adult's ability to serve in a school setting.

B. Any condition(s) which contraindicate employment in a school setting.

C. Recommendations:
 The above individual was found free from symptoms of communicable disease and otherwise able to discharge duties of the position applied for. YES NO Explain "NO":

Date of Examination: _____
 Physician's Signature and State License Number: _____
 Phone Number: _____ Address: _____