HEALTH EXAMINATION CERTIFICATE **North Carolina Public Schools**

Required of all persons upon initial employment, separation from employment for more than one school year, absence of more than 40 consecutive 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 above. Further I certify that this person is free of any other physical or mental disability that would impair job performance.

If unable to certify the above, please comment:

_____

_____

II. Other Health Areas

AREAS	LIMITATION 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: _____

NOTE: This form is to be completed by a Student Health Services employee or a private physician. If completed by a private physician, a copy of TB Test results from within the last year must be attached.