

**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: \_\_\_\_\_  
Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

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

Appropriate Immunizations	Current?		Any Immunization Recommendations
	YES	NO	
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.**