

Duplin County - Field Experience

1. Complete and submit the following documents:
 - a. North Carolina Health Examination Certificate
 - b. Background Check link will be sent Electronically to students from DCS
 - c. Share a PDF of your cleared and confirmed background check
2. Submit all completed documents through the Microsoft Form link available on the Field Experience website.
3. Placement confirmations will be provided by the Office of Educator Engagement and Student Success and reflected in the Brave Educator Dashboard. Be sure to check the dashboard regularly for updates.

Questions? Please contact the Director of Educator Engagement and Student Success, Dr. Kamina Fitzgerald, kamina.fitzgerald@uncp.edu

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: _____

#
Street
Apartment #

City
State
Zip Code

The above named individual is to be recommended for employment by _____ (local school board) in the position of _____ with _____ school/department. 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 <small>(Check Yes or No)</small>		NATURE OF LIMITATIONS <small>(continue with attachments as needed)</small>
	YES	NO	
Vision			
Hearing			
Heart			
Lungs			
Lifting/Carrying			

Appropriate Immunizations	Current? <small>(Check Yes or No)</small>		Any Immunization Recommendations
	YES	NO	
Td (tetanus), Hep B, MMR, etc.			
TB/PPD/Mantoux Test			

If the physical is not performed by the same licensed professional as the TB Skin/PPD/Mantoux test, please indicate the results of the test on a separate form.

Licensed Medical Professional License/Registration #/State: _____

Licensed Medical Professional (Print Name): _____

Licensed Medical Professional Signature: _____ Date (mm/dd/yy): _____

****PLEASE NOTE:** 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.**

Please provide this cover page along with the questionnaires and medical form to your health care provider in the event of a tuberculin shortage.

North Carolina General Statute § 115C-323 Employee Health Certificate for public school teachers states the following: *Any person initially employed in a public school or reemployed in a public school after an absence of more than one school year shall provide to the superintendent a certificate certifying that the person does not have any physical or mental disease, including tuberculosis in the communicable form or other communicable disease, that would impair the person's ability to perform his or her duties effectively.*

To comply with the statute as well as current guidelines of the Centers for Disease Control and Prevention, the following procedure is recommended for **all low-risk persons** requiring administrative screening for tuberculosis, including schoolteachers and other non-healthcare workers:

1) The healthcare provider performing the certifying examination should administer the Tuberculosis Risk Questionnaire and Tuberculosis Symptom Questionnaire (attached)

2) Persons who have negative responses to all questions on both the Tuberculosis Risk Questionnaire and Tuberculosis Symptom Questionnaire may be certified as not having tuberculosis in the communicable form.

No further testing is required for such persons.

3) Persons with any positive response on the Tuberculosis Symptom Questionnaire should receive further medical valuation, which should include a chest radiograph.

4) Persons with no positive responses on the Tuberculosis Symptom Questionnaire, but with any positive response on the Tuberculosis Risk Questionnaire should receive further medical evaluation, which should include either a tuberculin skin test or an interferon gamma release assay (written documentation of a prior positive test and subsequent negative chest radiograph is acceptable) .

This procedure represents best medical practice for persons requiring administrative testing, and should be followed even after the tuberculin shortage resolves.

Tuberculosis Risk Questionnaire

- | | | |
|--|-----|----|
| 1) Were you born outside the USA in one of the following parts of the world:
Africa, Asia, 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, worked or resided at a
homeless shelter, or worked as a healthcare worker in direct contact with
patients? | 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 |

Licensed Medical Professional License/Registration #/State: _____ (Print Name): _____

Licensed Medical Professional Signature: _____ Date (mm/dd/yy): _____