



# Herscher Community Unit School District No. 2

District Office: 501 N Main Street, PO Box 504, Herscher Illinois 60941

District Phone: 815-421-5000 - District Office Fax: 815-426-2872

## Pre-Employment History and Physical Examination Form

As a condition of employment in the Herscher School District, you must successfully pass an examination to determine that you are in good health.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

**To be completed by examining physician (physical examination must be performed by a physician licensed in the State of Illinois to practice medicine).**

Date of Examination: \_\_\_\_\_ General Appearance: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Allergies: \_\_\_\_\_

Temperature: \_\_\_\_\_ Pulse: \_\_\_\_\_ Respiration: \_\_\_\_\_ B/P: \_\_\_\_\_

System	Normal ?	
Skin	Yes <input type="checkbox"/> No <input type="checkbox"/>	If no, comments: _____
Eyes	Yes <input type="checkbox"/> No <input type="checkbox"/>	If no, comments: _____
Ears	Yes <input type="checkbox"/> No <input type="checkbox"/>	If no, comments: _____
Nose	Yes <input type="checkbox"/> No <input type="checkbox"/>	If no, comments: _____
Mouth/Throat	Yes <input type="checkbox"/> No <input type="checkbox"/>	If no, comments: _____
Cardiovascular	Yes <input type="checkbox"/> No <input type="checkbox"/>	If no, comments: _____
Respiratory	Yes <input type="checkbox"/> No <input type="checkbox"/>	If no, comments: _____

Current Medications: \_\_\_\_\_

(Attached additional sheet if needed)

Can applicant lift 25 lbs? Yes  No

Can applicant lift 50 lbs? Yes  No

Summary of Findings: \_\_\_\_\_

**I hereby certify that I have examined the above applicant and that the above is a complete and accurate record of my examination. I hereby state that this employee is in good physical health which is required to perform the essential functions of the position for which he/she is applying.**

Medical License #: \_\_\_\_\_

Printed Name: \_\_\_\_\_ M.D / D.O.

Signature: \_\_\_\_\_

Office Address: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

NAME: \_\_\_\_\_ POSITION: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ PH# \_\_\_\_\_  
IEIN: \_\_\_\_\_ EMAIL: \_\_\_\_\_  
DOB: \_\_\_\_\_  
SSN: \_\_\_\_\_