

# JEFFERSON COUNTY SCHOOLS PHYSICAL EXAMINATION FORM

**PART A – TO BE COMPLETED BY APPLICANT**

NAME \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

PHONE \_\_\_\_\_

Have you ever received treatment for, or been told by a physician or other practitioner that you have:

Yes	No		Yes	No	
_____	_____	Heart/Artery Disease	_____	_____	Arthritis
_____	_____	Chest Pain	_____	_____	Paralysis
_____	_____	High Blood Pressure	_____	_____	Bone/Muscle/Joint Disease
_____	_____	Cancer/Tumor/Polyp	_____	_____	Deformity of Bones
_____	_____	Diabetes	_____	_____	Glandular Disease
_____	_____	Lung Disease	_____	_____	Anemia, Leukemia or
_____	_____	Liver Disease	_____	_____	Other Blood Disease
_____	_____	Digestive Tract Disease	_____	_____	Disease/Impairment of
_____	_____	Mental Disorder	_____	_____	Eyes or Ears
_____	_____	Nervous System Impairment	_____	_____	Back Injuries/Surgery
_____	_____	Epilepsy	_____	_____	Prostate Disease
_____	_____	Allergies	_____	_____	Uterus/Ovary Disease
_____	_____	Urinary Tract Disease	_____	_____	Breast Disease

If you answered "yes" to any questions above, please give details including attending physician, dates of treatment and nature of disorder: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you applied for disability benefits in the past five years? Yes \_\_\_\_\_ No \_\_\_\_\_

If you answered "yes", please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I CERTIFY THAT THIS INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

**JEFFERSON COUNTY SCHOOLS  
PHYSICAL EXAMINATION FORM**

**PART B – TO BE COMPLETED BY PHYSICIAN**

I certify that I have examined \_\_\_\_\_

and find him/her to be in \_\_\_\_\_ Poor \_\_\_\_\_ Fair \_\_\_\_\_ Good \_\_\_\_\_ Excellent \_\_\_\_\_

health. He/She is capable of working under normal circumstances with the following  
restrictions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Remarks: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Physician Name (please print)

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

\_\_\_\_\_  
Date

**TB SCREENING REQUIRED**

**PLEASE ATTACH REPORT OF  
TUBERCULOSIS EVALUATION  
HERE**

\_\_\_\_\_  
PO Box 190 ~ 1221 Gay St.  
Dandridge, TN 37725

\_\_\_\_\_  
865-397-3194  
Fax 865-397-3301