



120 Park Ave., P.O. Box 49, Hebron, NE 68370  
 Phone: 402-768-6041 Fax: 402-768-4669

# PHYSICAL EXAMINATION FORM

Employer/School: \_\_\_\_\_

PLEASE RETURN THIS FORM TO YOUR EMPLOYER / SCHOOL AFTER IT HAS BEEN COMPLETED BY YOUR FAMILY PHYSICIAN.

NAME: \_\_\_\_\_ S.S.#: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Allergies: \_\_\_\_\_

	Normal	Abnormal-Describe
Skin		
Head		
Eye Grounds		
Ears		
Mouth & Throat		
Scalp		
Neck		
Thyroid		
Lymph Nodes		
Heart		
Lungs		
Abdomen		
Genitalia (inc. hernia)		
Back and Spine		
Extremities		
Neurological		
Psychiatric		
Epilepsy		
Diabetes		

Immunizations:	Date				
Hepatitis					
Tetanus					
Measles					
Mumps					
Rubella					

(Any additional lab work or x-rays will be at the expense of the prospective employee.)

TB Skin Test: \_\_\_\_\_

Urinalysis: \_\_\_\_\_

Hemoglobin (Optional): \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Significant Past Illness or Injury: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any contraindications to the receipt of any required vaccine: \_\_\_\_\_

Any special or unusual condition? \_\_\_\_\_

Current Medications: (list) \_\_\_\_\_

Physician Comments: \_\_\_\_\_

"I certify that I have on this date examined this patient and that on the basis of the examination requested by the employer/school and the patient's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this patient to be employed/participate at \_\_\_\_\_."

\_\_\_\_\_  
Date of Examination

\_\_\_\_\_  
Examining Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Signature