

Lopatcong Township School District

Lopatcong Township Elementary School
263 Route 57
Phillipsburg, New Jersey 08865
Phone: 908-859-0800
Fax: 908-213-1339

Rainie Roncoroni, Superintendent

Lopatcong Township Middle School
321 Stonehenge Drive
Phillipsburg, New Jersey 08865
Phone: 908-213-2995
Fax: 908-213-0373

Name of Employee: _____

Position: _____

School: _____

To be completed by employee:

1. Please describe any serious illness or injuries which you have had in the past:
2. Are you aware of any current health problem(s) or conditions(s)?
 Yes No
If yes, please specify:
3. Are you currently being treated by any physician(s) or other health care provider?
 Yes No
If yes, please state reason(s) and treatment(s):
4. Do you have any allergies? For example, bee stings, medication, foods?
 Yes No
If yes, to what are you allergic?

What type of treatment do you require for this allergy?

OPTIONAL: Under NJAC 6:29-7.4(d), you may wish to provide our school nurse and/or administration with information regarding medications you are taking as this information may be important to medical staff in the event of an emergency requiring treatment.

Please complete the following if you do wish to provide this information

Medication	Reason for taking medication	Treatment

I hereby certify that the above statements made by me are true:

Signature: _____

Date: _____

Name of Employee: _____ Position: _____

School: _____

To be completed by physician or health care provider:

Height: _____ Weight: _____ Blood pressure: _____ Pulse: _____

Vision: Right eye: _____ Left eye: _____ Both eyes: _____

Without correction: _____ With correction: _____

Hearing: Right ear: _____ Left ear: _____

Without correction: _____ With correction: _____

To be completed by school physician or employee's physician: If employee chooses to have a physical examination by his or her own physician, the employee is responsible for any cost incurred.

RESULT OF EXAMINATION:

I find no physical or mental condition likely to prevent the person examined from performing all duties and responsibilities of the position sought or occupied. This person's health is satisfactory.

Comments:

I find the following physical or mental conditions will likely prevent the person examined from performing all duties and responsibilities of the position sought or occupied. This person's health is unsatisfactory for the following reasons:

Comments:

Date examined

Signature of physician

I wish to share the health status information which I have provided on the reverse side with the school nurse and permit the nurse to keep such information in her file. This information may be valuable in case of emergency.

Date

Signature of employee

Note: This information will only be made available to the school nurse if you sign and date in the appropriate places. Otherwise, the form will be stored in office of the Superintendent.