



Clelian Heights

135 Clelian Heights Lane • Greensburg, PA 15601-6665 • (724) 837-8120 • fax (724) 837-6480

STAFF HEALTH APPRAISAL

To Be Completed By Employee

Name _____

Address _____

Phone _____

Purpose of Physical Examination

_____ Initial Employment _____ Annual Reexamination

Type of Work Activity (Check all that apply)

_____ Caring for children/adults _____ Food Prep _____ Driver _____ Maintenance

PART I To Be Completed By Health Professional

As shown by Physical Examination, does the individual have:

- | | | |
|--|-----|----|
| 1. At least 20/40 combined vision, corrected by glasses as needed? | YES | NO |
| 2. Color perception sufficient to distinguish between red, yellow, and green? | YES | NO |
| 3. Hearing in at least one ear at 2000, at frequencies of 500, 1000, and 2000? | YES | NO |
| 4. Normal blood pressure? | YES | NO |
| 5. Normal cardiovascular system? | YES | NO |
| 6. Normal respiratory system? | YES | NO |
| 7. Ability to climb two flights of stairs without distress? | YES | NO |
| 8. Normal skin? | YES | NO |
| 9. Normal neuromuscular skeletal systems? | YES | NO |
| 10. Normal endocrine system? | YES | NO |

PART II

Is the individual free from communicable Tuberculosis as shown by:

Tuberculin skin testing results must be read by a MD, DO, PA, CRNP, RN or LPN

11. Date Administered _____ Date Read _____ Negative Result YES NO

Please Print Name of Person who Read Test and Circle Credentials:

Name: _____ MD DO PA CRNP RN LPN

12. Positive skin test followed by one negative X-ray and an asymptomatic history at this health appraisal? YES NO

Please explain all "No" responses and plans for follow-up by using the reverse side of this form.

"For of such is the Kingdom of Heaven"

Email: Clelian@aol.com • www.clelianheights.org

PART III

Does the individual have any of the following medical problems:

13. History of heart problems?	YES	NO
14. History of epilepsy?	YES	NO
15. Diabetes?	YES	NO
16. Thyroid or other metabolic disorders?	YES	NO
17. Obesity?	YES	NO
18. Disabling emotional disorder?	YES	NO
19. Current drug or alcohol dependency?	YES	NO
20. Other special medical problems which require restriction of activity?	YES	NO
21. Medications which might affect work capacity?	YES	NO

Explain all "Yes" responses giving plans for follow-up below.

PLEASE PRINT:

Physician's Name _____

Address _____

Telephone _____

Date of exam _____

The above named person was examined this date and was found to be free on any communicable or infectious disease and to be without any physical or mental condition that would be a hazard to persons being cared for in a facility regulated or supervised by the Department of Public Welfare, or affect the duties required in the performance of his/her work.

Signature of Physician _____