WINSTON-SALEM/FORSYTH COUNTY SCHOOLS
HEALTH EXAMINATION CERTIFICATE

Required of all persons upon initial employment, separation from employment more than 90 days, absence of more than 40 successive days because of a communicable disease, or when deemed necessary by the board of education or superintendent. (Ref. NCCS 115C-323) **This form should be returned to Human Resources within 10 days from date of sign-up in HR Office.**

Name_____ Social Security Number_____

The above named individual is to be recommended for employment by the Winston-Salem/Forsyth County School System in a position of_____ at _____location. In this position, the condition of certain physical capacities will be of importance. Please examine the areas listed below and report any limitations, deficiencies or related restrictions.

AREAS	LIMITATIONS YES	NO	NATURE OF LIMITATIONS (continue on back if needed)
Vision			
Hearing			
Heart			
Lungs			
Lifting/Carrying			

Appropriate Immunizations	**CURRENT?** YES	NO	**Any Immunization Recommendations**
Td (tetanus), Hepatitis B, MMR, etc.			
PPD/TB Shot Received			Note: Must show negative result

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

By my signature I certify that the above named person does not have any communicable disease, including tuberculosis, that poses a significant risk of transmission in our schools or would impair this person's ability to perform the duties of the job, except as may be noted above. Further, I certify that this person is free of any other physical or mental disability that would impair job performance.

If unable to certify the above, please comment: _____

_____

Date: _____

_____
Name of Physician (printed or typed)

_____
Signature of Physician

License/Registration #:_____ State Granting License/Registration _____

Human Resources use only:

HR Representative _____ Date_____