



Miami-Dade County Public Schools Medical Examination Report for Fitness Determination

1. CONTACT INFORMATION Applicant completes this section						
Name (Last, First, Middle)		Social Security No.	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Position	Date
Address			City, State, Zip Code		Work Telephone	
					Home Telephone	
2. MEDICAL HISTORY Applicant completes this section, but medical examiner is encouraged to discuss with applicant.						
Yes No		Yes No		Yes No		
<input type="checkbox"/>	<input type="checkbox"/>	Any illness or injury in last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	Muscular disease	
<input type="checkbox"/>	<input type="checkbox"/>	Head/Brain injuries, disorder, or illnesses	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures, epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease, emphysema, asthma, chronic bronchitis	
	<input type="checkbox"/>	Medication _____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease, dialysis	
<input type="checkbox"/>	<input type="checkbox"/>	Eye disorders or impaired vision (except corrective lenses)	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	
<input type="checkbox"/>	<input type="checkbox"/>	Ear disorders, loss of hearing or balance	<input type="checkbox"/>	<input type="checkbox"/>	Digestive problems	
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease or heart attack; other cardiovascular condition	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or elevated blood sugar controlled by:	
	<input type="checkbox"/>	Medication _____		<input type="checkbox"/>	diet	
<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery (valve replacement/bypass, angioplasty, pacemaker)		<input type="checkbox"/>	pills	
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure		<input type="checkbox"/>	insulin	
	<input type="checkbox"/>	Medication _____	<input type="checkbox"/>	<input type="checkbox"/>	Nervous or psychiatric disorders, e.g., severe depression	
				<input type="checkbox"/>	Medication _____	
Yes No			Yes No			
<input type="checkbox"/>	<input type="checkbox"/>	Loss of, or altered consciousness	<input type="checkbox"/>	<input type="checkbox"/>	Missing or impaired hand, arm, foot, leg, finger, toe	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting, dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Spinal injury or disease	
<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	<input type="checkbox"/>	<input type="checkbox"/>	Chronic low back pain	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke or paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Regular, frequent alcohol use	
			<input type="checkbox"/>	<input type="checkbox"/>	Narcotic or habit forming drug use	
For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently.			Medical Examiner's Comments on Health History (The medical examiner must review and discuss with the applicant any "yes" answers and potential hazards of medications, including over-the-counter medications.)			
_____			_____			
_____			_____			
_____			_____			
I certify that the above information is complete and true. I understand that inaccurate, false, or missing information may invalidate the examination and my Medical Examiner's Certificate.			_____			
_____			_____			
Applicant's Signature			Date			

3. VISION Testing (Medical Examiner completes Sections 3 through 7)			
Standard: At least 20/40 acuity (Snellen) in each eye with or without correction. At least 70 peripheral in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.			
Numerical readings must be provided.			
ACUITY	UNCORRECTED	CORRECTED	NATIONAL FIELD OF VISION
Right Eye	20/	20/	Right Eye °
Left Eye	20/	20/	Left Eye °
Both Eyes	20/	20/	°
INSTRUCTIONS: When other than the Snellen chart is used, give test results in Snellen-compared values. In recording distance vision, use 20 feet as normal. Report visual acuity as a ratio with 20 as numerator and the smallest type read at 20 feet as denominator. If the applicant wears corrective lenses, these should be worn while visual acuity is being tested. If the applicant habitually wears contact lenses, or intends to do so, sufficient evidence of good tolerance and adaptation to their use must be obvious.			
Applicant can recognize and distinguish among devices showing standard red, green, and amber colors? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Applicant meets acuity requirement only when wearing: <input type="checkbox"/> Corrective Lenses			
Monocular Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No			

4. HEARING Standard: a) Must first perceive forced whispered voice \geq 5ft., with or without hearing aid, or b) average hearing loss in better ear \leq 40 dB.

Check if hearing aid used for tests. Check if hearing aid **required** to meet standard.

INSTRUCTIONS: To convert audiometric test results from ISO to ANSI, -14dB from ISO for 500Hz, -10dB for 1,000 Hz, -8.5 dB for 2,000 Hz. To average, add the readings for 3 frequencies tested and divide by 3.

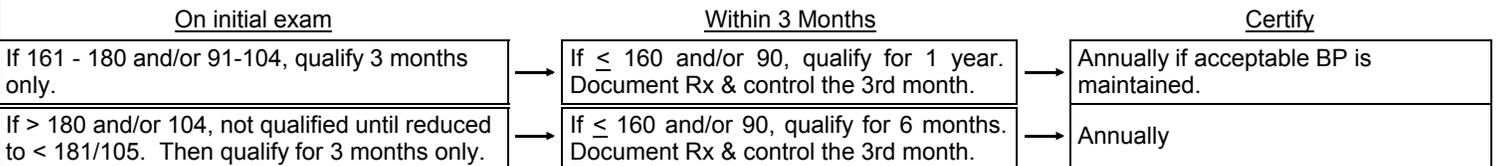
Numerical readings must be recorded.

a) Record distance from individual at which forced whispered voice can first be heard.	Right Ear	Left Ear	RIGHT EAR			LEFT EAR		
	Feet	Feet	500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz
a) If audiometer is used, record hearing loss in decibels. (acc. To ANSI Z24.5-1951)			Average:			Average:		

5. BLOOD PRESSURE/PULSE RATE Numerical readings must be recorded.

Blood Pressure	Systolic	Diastolic	Applicant qualified if \leq 160/90 on initial exam.	Pulse Rate	<input type="checkbox"/> Regular
					<input type="checkbox"/> Irregular

GUIDELINES FOR BLOOD PRESSURE EVALUATION



Medical examiner should take at least 2 readings to confirm blood pressure.

6. LABORATORY AND OTHER TEST FINDING Numerical readings must be recorded.

Urinalysis is required. Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem. *Other Testing (Describe and record)*

Urine Specimen	Spec. Gravity	Protein	Blood	Sugar
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7. PHYSICAL EXAMINATION Height: _____ (in.) Weight: _____ (lbs)

The presence of a certain condition may not necessarily disqualify an applicant, particularly if the condition is controlled adequately, is not likely to worsen, or is readily amenable to treatment. Even if a condition does not disqualify an applicant, the medical examiner may consider deferring the applicant temporarily. Also, the applicant should be advised to take the necessary steps to correct the condition as soon as possible, particularly if the condition, if neglected, could result in more serious illness.

Check YES if there are any abnormalities. Check NO if the body system is normal. Discuss any YES answers in detail in the space below, and indicate whether it would affect the applicant's ability to perform the duties of the position. Enter applicable item number before each comment. If organic disease is present, note that it has been compensated for.

BODY SYSTEM	CHECK FOR:	YES	NO
1. General Appearance	Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse.		
2. Eyes	Pupillary equality, reaction to light, accommodation, ocular motility, ocular muscle imbalance, extraocular movement, nystagmus, exophthalmos, strabismus uncorrected by corrective lenses, retinopathy, cataracts, aphakia, glaucoma, macular degeneration.		
3. Ears	Middle ear disease, occlusion of external canal, perforated eardrums.		
4. Mouth and Throat	Irremediable deformities likely to interfere with breathing or swallowing.		
5. Heart	Murmurs, extra sounds, enlarged heart, pacemaker.		
6. Lungs and chest, not including breast examination	Abnormal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezes or alveolar rates, impaired respiratory function, dyspnea, cyanosis. Abnormal findings on physical exam may require further testing such as pulmonary tests and/or x-ray of chest.		
7. Abdomen and Viscera	Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abnormal wall muscle weakness.		
8. Vascular system	Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins.		
9. Genito-urinary system	Hernias		
10. Extremities-Limb impaired. Driver may be subject to SPE certificate if otherwise qualified.	Loss or impairment of leg, foot, toe, arm, hand, finger. Perceptible limb, deformities, atrophy, weakness, paralysis clubbing, edema, hypotonia. Insufficient grasp and prehension in upper limb to maintain steering wheel grip. Insufficient mobility and strength in lower limb to operate pedals properly.		
11. Spine, other musculoskeletal	Previous surgery, deformities, limitation of motion, tenderness.		
12. Neurological	Impaired equilibrium, coordination, or speech pattern; paresthesia, asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinski's reflexes, ataxia.		

*COMMENTS: _____

- Meets standards
- Does not meet standards
- Meets standards, but periodic evaluation required
Due to _____
- Temporarily disqualified due to (condition or medication): _____
Return to medical examiner's office for follow up on _____
- Wearing corrective lenses
- Wearing hearing aid
- Accompanied by a _____ waiver/exemption

MEDICAL EXAMINER'S CERTIFICATE

PHYSICAL REQUIREMENTS (Custodians)

This is heavy work which requires the following physical activities: climbing, balancing, kneeling, crouching, crawling, twisting, reaching, standing, walking, pushing, pulling, lifting (40 lbs. minimum), finger dexterity, grasping, feeling, repetitive motions, talking, hearing and visual acuity. The worker is exposed to cold, heat, noise, vibration, hazards, oils and atmospheric conditions. The work is performed indoors and outdoors. May be required to work fourteen (14) feet above the floor or ground level with or without reasonable aids and be able to perform cleaning tasks at forty-feet (40) above the ground or floor when requested.

I have examined the applicant and have certified that he is able to perform the physical requirements of the position as described.

Signature of Medical Examiner	Telephone	Date
Medical Examiner's Name (Print)	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Chiropractor <input type="checkbox"/> Advance Practice Nurse	
Medical Examiner's License or Certificate No. / Issuing State		
Signature of Applicant		

* Affix Doctor's Seal or Professional
Business Card Here