North Carolina Public Schools Health Examination Certificate

Henderson County Schools

Required of all persons upon initial employment, separation from employment more than one school year, absence of more than 40 successive days because of a communicable disease, or when deemed necessary by a local school board or superintendent. (Ref. NCGS 115C-323)

Name: _____ Social Security Number: (Last 6 only) _____

Address: _____

The above-named individual is to be recommended for employment by Henderson County Board of Education, in the position of: _____. 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.

I. Communicable Disease

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 below. Further, I certify that this person is free of any physical or mental disability that would impair job performance.

If unable to certify the above, please comment:

_____

_____

II. Other Health Areas (REQUIRED to check Yes or No)

AREAS	LIMITATIONS YES	NO	NATURE OF LIMITATIONS (Continue on back as needed)
Vision			
Hearing			
Heart			
Lungs			
Lifting/Carrying			
APPROPRIATE IMMUNIZATIONS	**Up-to-Date per ACIP? (REQUIRED to Check) YES**	**NO**	**Dates of Administration (If Applicable) (or illness to prove immunity. Applicant may provide copy of immunization record for date verification)**
Tdap (Tetanus, Diphtheria, Pertussis)			
MMR (Measles, Mumps, Rubella)			
Varicella (Chickenpox)			
Hepatitis B (if applicable example for			
Custodians/Maint Staff)			

Applicant is required to bring/provide any health and immunization records for Physician, Physician Assistant or Nurse Practitioner to review to assist in completing the health and immunization sections of form

Date: _____ Immunization recommendations: _____

Name of (PRINTED) Physician, Physician Assistant or Nurse Practitioner _____

Signature of Physician, Physician Assistant or Nurse Practitioner _____

License/Registration# _____ State *Granting License/Registration _____

*For initial employment of an out-of-state applicant, the certificate may be completed by a health care provider with an out-of-state unrestricted, current license or registration. *(**ACIP is the CDC Advisory Committee on Immunizations)*

Note from the Henderson County Health Department: They can ONLY assist with providing immunizations, will not sign form.

Revised 11/2022