VG #05-195689-N W-251954

NEW YORK CITY DEPARTMENT OF EDUCATION
Office of Pupil Transportation
44-36 Vernon Boulevard 6th Floor
Long Island City, New York 11101

MEDICAL EXAMINATION

☐ **ATTENDANT**

Name	**Signature**	
Address	**Date of Birth**	**Age**
City, State, Zip	**S.S. Number**	**Date**

HEALTH HISTORY

YES	NO		YES	NO		YES	NO	
☐	☐	HEAD OR SPINAL INJURY	☐	☐	GONORRHEA	☐	☐	KIDNEY DISEASE
☐	☐	SEIZURES OR FAINTING	☐	☐	DIABETES	☐	☐	MUSCULAR DISEASE
☐	☐	SEVERE INJURY OR ILLNESS	☐	☐	G.I. ULCER	☐	☐	ANY DISEASE
☐	☐	CARDIO VASCULAR DISEASE	☐	☐	NERVOUS STOMACH	☐	☐	PERMANENT DEFECT
☐	☐	T B	☐	☐	RHEUMATIC FEVER	☐	☐	PSYCHIATRIC DISORDER
☐	☐	SYPHILIS	☐	☐	ASTHMA	☐	☐	OTHER NERVOUS DISORDER

Give explanation for each YES answer

PHYSICAL EXAMINATION

Based on Regulation 6.11 Of Commissioner's Regulations

GENERAL APPEARANCE ☐ Good ☐ Fair ☐ Poor

Note: Visual Acuity of at Least 20/40 Required in Each Eye With Field of Vision of 70° Horizontal Meridian in Each Eye.

VISION For Distance RT	LT	Corrective Lenses	Disease or Injury RT	LT	Color Test	Visual Field RT	LT	BOTH
20/	20/	☐ Yes ☐ No						

Hearing RT	LT	Test Used	Disease or injury RT	LT	Audiometric (if done) Loss at 500 HZ RT	LT	Loss at: 1000 HZ RT	LT	Loss at: 2000 HZ RT	LT

Nose	Throat	Lungs	Heart	Organic Disease	Compensated	Blood Pressure	Pulse at Rest	After Exercise

Abdomen SCARS	MASSES	TENDERNESS	HERNIA	LOCATION	Is Truss Worn? ☐ Yes ☐ No	G.I. Ulceration Disease ☐ Yes ☐ No	G.U. Scars	Discharge

Reflexes: Romberg	Pupillary RT	LT	Knee Jerks: RT ☐ Normal ☐ Increased ☐ Absent	LT ☐ Normal ☐ Increased ☐ Absent

Extremities: Upper	Lower	Spine	Urine: Albumin	Urine: Sugar	If Necessary: Serology	E. K. G.

Radiological Data	Negative Date _____	Positive Date _____	Comments

I certify that I have examined the above in accordance with the Commissioner's Regulations and with knowledge of his duties. in accordance with Regulation 6.11. I find:

☐ The above named person is physically or medically qualified

☐ The above named person is **not** physically or medically qualified because

_____

☐ Restrictions and/or Followup

☐ Qualified only when wearing corrective lenses

☐ Qualified only when wearing hearing aid

☐ Certification every six months for diabetic condition

_____ _____
(Print Examining Doctor's Name) (Signature of Examining Doctor)

_____
(Address of Examining Doctor)

BE/OPT 9609 (5/12)

THE CARRIER MUST KEEP A COPY OF THIS EXAMINATION REPORT IN THE EMPLOYEE'S FILE
IF ADDITIONAL SPACE IS REQUIRED, PLEASE USE REVERSE SIDE.

CONTRACTOR COPY

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OPT COPY