Clear Form

Miami-Dade County Public Schools
Office of Support Personnel Staffing
Medical Examination Report for Fitness Determination

1. CONTACT INFORMATION
Applicant completes this section

Name (Last, First, Middle)	Birthdate	Sex	Position	Date
		☐ M ☐ F		

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	
☐	☐	Any illness or injury in last 5 years?
☐	☐	Head/Brain injuries, disorder, or illnesses
☐	☐	Seizures, epilepsy
	☐	Medication _____
☐	☐	Eye disorders or impaired vision (except corrective lenses)
☐	☐	Ear disorders, loss of hearing or balance
☐	☐	Heart disease or heart attack; other cardiovascular condition
	☐	Medication _____
☐	☐	Heart surgery (valve replacement/bypass, angioplasty, pacemaker)
☐	☐	High blood pressure
	☐	Medication _____

Yes	No	
☐	☐	Muscular disease
☐	☐	Shortness of breath
☐	☐	Lung disease, emphysema, asthma, chronic bronchitis
☐	☐	Kidney disease, dialysis
☐	☐	Liver disease
☐	☐	Digestive problems
☐	☐	Diabetes or elevated blood sugar controlled by:
	☐	diet
	☐	pills
	☐	insulin
☐	☐	Nervous or psychiatric disorders, e.g., severe depression
	☐	Medication _____

Yes	No	
☐	☐	Loss of, or altered consciousness
☐	☐	Fainting, dizziness
☐	☐	Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring
☐	☐	Stroke or paralysis

Yes	No	
☐	☐	Missing or impaired hand, arm, foot, leg, finger, toe
☐	☐	Spinal injury or disease
☐	☐	Chronic low back pain
☐	☐	Regular, frequent alcohol use
☐	☐	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.

_____
_____
_____

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

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.)

_____
_____
_____
_____
_____
_____
_____
_____

Testing (Medical Examiner completes Sections 3 through 7)

3. VISION

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? ☐ Yes ☐ No

Applicant meets acuity requirement only when wearing: ☐ Corrective Lenses

Monocular Vision: ☐ Yes ☐ No

4. HEARING **Standard: a) Must first perceive forced whispered voice ≥ 5ft., with or without hearing aid, or b) average hearing loss in better ear ≤ 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.

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

RIGHT EAR			LEFT EAR		
500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz
Average:			Average:		

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

Blood Pressure	Systolic	Diastolic

Applicant qualified if ≤ 160/90 on initial exam.

Pulse Rate	☐ Regular ☐ Irregular

GUIDELINES FOR BLOOD PRESSURE EVALUATION

On initial exam	Within 3 Months	Certify
If 161 - 180 and/or 91-104, qualify 3 months only.	If ≤ 160 and/or 90, qualify for 1 year. Document Rx & control the 3rd month.	Annually if acceptable BP is maintained.
If > 180 and/or 104, not qualified until reduced to < 181/105. Then qualify for 3 months only.	If ≤ 160 and/or 90, qualify for 6 months. Document Rx & control the 3rd month.	Annually

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

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)	☐ MD ☐ DO ☐ Chiropractor ☐ Advance Practice Nurse	
Medical Examiner's License or Certificate No. / Issuing State		
Signature of Applicant		

* Affix Doctor's Seal or Professional Business Card Here