CCSD
CLARK COUNTY
SCHOOL DISTRICT

Confidential Medical History

CLARK COUNTY SCHOOL DISTRICT

HUMAN RESOURCES DIVISION

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH
ADDRESS	SOCIAL SECURITY NUMBER
PERSONAL PHYSICIAN'S NAME	POSITION

Date medical history completed:_____

Please check appropriate category:

☐ Licensed ☐ Administrative ☐ Support Staff ☐ School Police

Please complete the following information about your health and medical history. If the answer to any of the following questions is "YES," please explain in the space provided on the reverse side.

	YES	NO
1. Have you ever had any trouble with your heart or been told that you had trouble with your heart?	☐	☐
2. Have you been treated for high blood pressure or been told by a medical professional that your blood pressure was not normal?	☐	☐
3. Have you been hospitalized overnight for any reason in the past five years?	☐	☐
4. In the past twelve (12) months, have you seen a doctor for anything other than routine checkups?	☐	☐

5. Have you now, or have you ever had (check each item and where multiple conditions are listed, circle the condition(s) that apply.):

YES	NO		
☐	☐	A.	Chest pain or pressure
☐	☐	B.	Palpitation or pounding heart
☐	☐	C.	Swelling of feet or ankles
☐	☐	D.	Chronic headache or throbbing temples
☐	☐	E.	Chronic nasal obstruction, discharge or nose bleed
☐	☐	F.	Sinusitis, hay fever or sensitivity to dust
☐	☐	G.	Lung trouble
☐	☐	H.	Fever, chills or night sweats
☐	☐	I.	Hernia or rupture
☐	☐	J.	Eye trouble (pain, burning, itching, etc.)
☐	☐	K.	Poor sight or wear glasses or contact lenses
☐	☐	L.	An eye injury or an artificial eye
☐	☐	M.	Double vision
☐	☐	N.	Ear trouble (injury, pain, ringing, discharge, etc.)
☐	☐	O.	Loss of hearing or wear a hearing aid
☐	☐	P.	Abnormality of smell, taste, touch or feel
☐	☐	Q.	Neuritis or bursitis
☐	☐	R.	Dizziness or fainting spells
☐	☐	S.	Tremors, spasms, fits, convulsions or epilepsy

YES	NO		
☐	☐	T.	Painful or trick elbow or shoulder
☐	☐	U.	Painful, trick or locked knee
☐	☐	V.	Foot trouble, or leg cramps
☐	☐	W.	Bone, joint or other deformity
☐	☐	X.	Back injury, back pain, backache or back brace
☐	☐	Y.	Joint or muscle pain, arthritis or rheumatism
☐	☐	Z.	Psoriasis, dermatitis or eczema
☐	☐	AA.	Rash due to chemicals, oils, latex, plastics, etc.
☐	☐	BB.	Allergy or hives
☐	☐	CC.	Reaction to a drug, serum or medicine
☐	☐	DD.	Diabetes, or tuberculosis
☐	☐	EE.	Illness or injury from chemical exposure
☐	☐	FF.	Excessive bleeding after injury
☐	☐	GG.	Illness or injury due to work
☐	☐	HH.	Loss of strength or easy fatigue
☐	☐	II.	Photo sensitivity (reaction to sunlight)
☐	☐	JJ.	Numbness, tingling of joints and/or extremities
☐	☐	KK.	Other conditions that may interfere with your work

	NUMBER OF PACKS, CIGARS, PIPEFULS, ETC.	YES	NO
6. Do you smoke? If you answer yes, indicate how much per day:		☐	☐
7. Have you experienced any prolonged shortness of breath?		☐	☐
8. Do you have regular episodes of coughing?		☐	☐
9. Do you drink alcoholic beverages? If yes, indicate daily quantity:	INDICATE BEVERAGE & QUANTITY	☐	☐

(Please continue on the reverse side)

Revised 5/11/07

	YES	NO
10. Do you consider yourself overweight?	☐	☐
11. Have you worked in the following occupations? If so, how long?	☐	☐

Asbestos _____	Grinding _____	Chrome painting _____	Other _____
Battery mfg. _____	Mining (kind) _____	Sandblasting _____	_____
Beryllium processing _____	Radium dial painting _____	Silica _____	_____
Brick mfg. _____	Paint mfg. _____	Spray or brush painting _____	_____
Die finishing _____	Polishing _____	Stone cutting _____	_____
Foundry _____	Pottery _____	Uranium processing _____	_____
Glass mfg. _____	Quarrying _____	Welding _____	_____

12. Has your past employment been restricted or have you been restricted from jobs requiring:

YES	NO		
☐	☐	A.	Anything other than seated work
☐	☐	B.	Repeated bending, stooping, twisting or lifting over _____ pounds
☐	☐	C.	Prolonged kneeling or squatting
☐	☐	D.	Any kneeling or squatting
☐	☐	E.	Walking up any steps
☐	☐	F.	Work on ladders or overhead
☐	☐	G.	Arms above shoulder level
☐	☐	H.	Exposure to dust or other particles
☐	☐	I.	Exposure to airborne chemicals
☐	☐	J.	No work with or exposure to chemicals
☐	☐	K.	Work requiring use of occlusive clothing

YES	NO		
☐	☐	L.	Accurate far vision
☐	☐	M.	Accurate near vision
☐	☐	N.	True color perception
☐	☐	O.	True depth perception
☐	☐	P.	Good Hearing
☐	☐	Q.	Exposure to excessive noise
☐	☐	R.	Work around moving machinery
☐	☐	S.	Operation of moving machinery
☐	☐	T.	Operation of motor vehicle
☐	☐	U.	Exposure to solvents or thinners
☐	☐	V.	Exposure to oils, resins or fiberglass
☐	☐	W.	Mental tension or responsibility
☐	☐	X.	Any industrial type of physical activity

Comments: If you answered "yes" to any of the preceding questions/items (page 1 or 2), please indicate the question/item number below and explain. (Please attach additional sheets as required.)

QUESTION/ITEM	EXPLANATION
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

13. Do any of the medical conditions identified by you on this medical history form require some type of accommodation to enable you to perform the essential functions of the job for which you have applied?

YES ☐ **NO** ☐

If you answered "yes" to question 13, please identify the accommodation you feel you will need on the lines below.

ACCOMODATION(S) NEEDED

_____

_____

_____

The information provided on this Confidential Medical History will be kept separate from your personnel file. It will be available to your administrative supervisors if they have a work-related need to know, medical personnel who may be required to treat you, and workers compensation offices and insurance companies if a claim is filed.

I certify that, to the best of my knowledge, the foregoing answers are complete and correct, and I understand that any omission, misrepresentation of fact, or falsification of this record are grounds for dismissal.

_____ _____

Signature of Individual Completing History | Date