MEDICAL EXAMINATION OF SCHOOL EMPLOYEES

This is to certify that I have examined _____

and find (him or her) free of communicable disease and any physical or mental disabilities that might interfere with performing (his or her) duties, except as follows:

_____

_____

_____

_____

_____

_____ _____**M.D.**

Date of Examination Signature

DATE:

Adopted:
Reviewed:
Revised: March 1, 2006
Cancellation: