NEW YORK CITY BOARD OF EDUCATION
OFFICE OF PUPIL TRANSPORTATION
33-00 Northern Boulevard
Long Island City, N.Y. 11101

MEDICAL EXAMINATION

☐ ESCORT

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 Neccesary: 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 (5/84)

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