

**Sequatchie Valley Head Start  
Physical Exam Form**

**Employee Name:** \_\_\_\_\_

**Check type of physical / certification:**

- return to work physical
- post employment offer physical
- routine periodic physical

**Position:**

- Nutrition Worker
- Kitchen Aide / Volunteer

**Essential functions of positions** (work with disabled preschoolers is required for all positions)

Applicant / Employee must be able to:

- pick up an injured child (3-5 years old) and carry to another location where first aid can be administered
- lift 50-plus pound child from floor to carrying position
- remove a fire extinguisher weighing approximately 15 pounds from its mount, carry, and use if needed
- maintain body equilibrium to prevent falling when walking, standing, crouching, or running on narrow, slippery, or erratically moving surfaces; ability to climb on a step stool, stairs, ramps, using feet and legs and/or hands and arms
- lift objects from the floor to 18 inches above the shoulder and reach in kitchen environment, including loading and unloading dishwasher
- kneel, bend, stoop, reach, and sit in child-size furniture for 30 minutes or longer at mealtime
- serve as a role model following gross motor activities described in songs or written direction
- express or exchange ideas by means of spoken word
- hear (may utilize assistive devices) for those activities which require ability to receive detailed information through oral communication
- perceive the nature of objects through sight; ability to visually monitor a class of three and four year olds
- adapt to abrupt variations in temperature which accompany extreme heat or cold; work in kitchen with extreme heat related to ovens, commercial dishwashers, microwaves, and hot food
- tolerate contact with water or other liquids and be exposed to nontoxic noxious smells
- shop for food and kitchen supplies (on and off premises); complete shopping list; discern items in store; complete paper related to purchasing; put purchases items on shelves and/or in freezer

*Form continues on next page*

**To be completed by physician:**

1. Is the employee able to perform the functions of this employees' position?

Yes       No

2. If no, is the employee able to perform work on any kind?

Yes       No

Describe limitations or work alternatives and mark any limitations on first page:

\_\_\_\_\_

\_\_\_\_\_

3. Does this employee/applicant because of a communicable disease, pose a significant risk to the health or safety of other in the Head Start program that cannot be eliminated or reduced by reasonable accommodation?

Yes       No

4. We require physicals to be done once per year for bus drivers and employees taking prescription medication on a regular basis or with chronic illnesses. When do you recommend that another physical be done for this employee?

1 year     2 years     3 years     Other: \_\_\_\_\_

**New Employees Only:**

TB screening results (required for all new employees): \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Physician or Practitioner: \_\_\_\_\_

Date: \_\_\_\_\_ Type of Practice: \_\_\_\_\_

Employee must sign after completion of report by physician. Signature indicates that full disclosure of medical history / conditions has been discussed with physician or practitioner.

Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_