TO: All New Staff Members
FROM: Office of the Superintendent
RE: Physical Examination – New Employees

All new employees are required to undergo a physical examination as conducted by a NJ licensed medical doctor or a NJ licensed nurse practitioner. (NJAC 6:3-4A.4) Attached you will find a form that must be completed by your medical assessor. The completed form must be signed by your doctor/nurse practitioner and returned to the superintendent of schools as soon as possible. Employees may also choose to provide the building principal and/or the school nurse health status information, including medications, which may be of value to medical personnel in the event of an emergency requiring treatment.

Further, the code mandates that only the employee, the Superintendent, and the school medical inspector shall have access to medical information in that individual’s file, unless permission is given by the employee.

The pre-employment physical examination shall not be used to determine a candidate’s disabilities, only to determine whether the applicant is able to perform with reasonable accommodation job-related functions pursuant to the Americans with Disabilities Act of 1990. Any examinations or assurances required shall be limited to those assessments or information necessary to determine the individual’s physical and mental fitness to perform in the position which he or she seeks and to detect any health risks to students and other employees.

bd
Attachments
Rev. 5/04
Dear Employee:

According to the NJ State Department of Education regulations for school tuberculin testing – NJAC 6:29-2.3, “a Mantoux intradermal tuberculin test shall be given upon employment to all newly-hired employees (full-time and part-time), all students teachers, school bus drivers for companies under contract with the district, and other persons who have contact with pupils.”

1. Written proof of having had a Mantoux tuberculin test as follows:
   a. New employee who has had the test in the previous six months;
   b. Employee transferring between school districts or a non-public school within New Jersey who has had a Mantoux tuberculin test administered upon his/her initial employment in a New Jersey school.

2. If no proof of a Mantoux tuberculin test, a Mantoux must be administered by a physician of your choice at your own expense.

3. If having been a previous TB reactor, proof from a physician to that fact, plus a recent chest x-ray report must be presented.

4. Proof must be sent directly to:

   Monroe Township Board of Education
   Superintendent’s Office
   423 Buckelew Avenue
   Monroe Township, NJ 08831

5. Proof of TB testing must be presented before Board approval of your employment.

6. Failure to comply with these regulations may result in your not being able to assume your responsibilities and render you unable to work.

Thank you for your cooperation.

Very truly yours,

Marietta Ruela
Director Pupil Personnel Services

MR:rz
Rev. 02/12
Verification of Mantoux Tuberculin Testing

For All New Employees*

(Form to be completed by the Physician)

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Remarks (optional):

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NOTE: THE MANTOUX TEST IS THE ONLY ACCEPTED METHOD OF TESTING ACCORDING TO N.J.A.C. 6:29-4.2

(2/12)
Monroe Township Schools

Physical Examination Report - New Employee

Employee Name: ___________________________________________________________

Address: __________________________________________________________________

Telephone: (___)____________________ Weight:___________   Height: ____________

Previous Illnesses and Injuries (physical/mental): _______________________________
__________________________________________________________________________
__________________________________________________________________________

Allergies (Food, Drug, or other): _____________________________________________

Immunizations:  ___________________________________________________________

Pulse Rate: ________________________________________________________________

Blood Pressure: ____________________________________________________________

Vision Screening Results: ___________________________________________________

Hearing Screening Results: _________________________________________________

Medications Prescribed: ____________________________________________________

General Health Condition:   _______ Good   _______ Other

Physician’s Evaluation and Remarks: _________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

___________________________________  ________________________________
Physician’s Name (Print or type)        Physician’s Signature

___________________________________  ________________________________
Physician’s Address                    Physician’s Signature

___________________________________  ________________________________
Telephone                          Date