PRE-EMPLOYMENT MEDICAL EVALUATION

CITY OF PHILADELPHIA
DEPARTMENT OF PARKS & RECREATION

PERSONAL INFORMATION

NAME *(LAST)* *(FIRST)* *(MIDDLE)*	BIRTHDATE	SEX ☐ M ☐ F	SOCIAL SECURITY NUMBER

ADDRESS *(CITY)* *(STATE)* *(ZIP CODE)*	HOME TELEPHONE NO.	ALT. TELEPHONE NO.

PRIMARY PHYSICIAN	ADDRESS *(CITY)* *(STATE)* *(ZIP CODE)*

TELEPHONE NO.	INSURANCE PROVIDER	INSURANCE ID NO.

MEDICAL CONDITIONS	Yes	No	If Yes, Explain:
Allergies	☐	☐	
Asthma	☐	☐	
Cardiac	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder	☐	☐	
Hypertension	☐	☐	
Neuromuscular Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder	☐	☐	Uncorrected: Corrected:
Other (*Specify*)	☐	☐	

VACCINATIONS	Yes	No	If Yes, Date (s):
COVID-19	☐	☐	
Standard Childhood Vaccinations	☐	☐	
Hepatitis A	☐	☐	
Hepatitis B	☐	☐	
Tuberculosis	☐	☐	
Flu	☐	☐	
MMR	☐	☐	
Td/Tdap	☐	☐	
Chicken Pox (vaccine or illness)	☐	☐	

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her performance of duties? If so, specify_____

Examiner Name (Print)	Examiner Signature	License No.	Date