Note: The physical is at your cost if you are a Certified Staff Member or Substitute Teacher. You may choose your own physician. Information for Advocate-Sherman HealthCare is provided only as an option for you.

**Advocate-Sherman Outpatient Centers**

- **Elgin – Royal Blvd.**
  - 2320 Royal Blvd.
  - Elgin, IL 60123
  - (224) 783-4440
  - Hours: M-F 6:00 a.m. – 9:30 p.m.
  - Sat. 7:00 a.m. – 4:00 p.m.
  - Sun. 7:00 a.m. – 4:00 p.m.

- **Algonquin Facility**
  - 600 South Randall Road
  - Algonquin, IL 60102
  - (224) 783-4300
  - Hours: Daily 6:00 a.m. – 11:00 p.m.

- **South Elgin**
  - 2000 McDonald Road
  - South Elgin, IL 60177
  - (224) 783-5000
  - Hours: M-F 6:00 a.m. – 9:30 p.m
  - Sat. 7:00 a.m. – 4:00 p.m.
  - Sun. 7:00 a.m. – 4:00 p.m.
I hereby authorize the examining physician to release the results of this examination and all tests to a representative of Community Unit School District No. 300

<table>
<thead>
<tr>
<th>Name of Examinee (Please Print)</th>
<th>Signature of Examinee</th>
</tr>
</thead>
</table>

**I. IDENTIFYING DATA:**

Name__________________________  Sex _______  Birth Date ____________

**II. GENERAL PHYSICAL CONDITION:**

Height _______________  Weight _____________

\[\begin{array}{ccc}
\text{Corrected} & \text{Uncorrected} \\
\text{Lt} & \text{Rt} & \text{Hearing} & \text{Heart} \\
\end{array}\]

Blood Pressure:
Normal _______________  High _______________  Low _______________

**III. REQUIRED TEST:**

<table>
<thead>
<tr>
<th>Test</th>
<th>Type</th>
<th>Date</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculin</td>
<td>Mantoux</td>
<td>______</td>
<td>________</td>
</tr>
<tr>
<td>Albumen</td>
<td>Urine Dip</td>
<td>______</td>
<td>________</td>
</tr>
<tr>
<td>Sugar</td>
<td>Urine Dip</td>
<td>______</td>
<td>________</td>
</tr>
<tr>
<td>Cannabis</td>
<td>5 Panel</td>
<td>______</td>
<td>________</td>
</tr>
<tr>
<td>Cocaine</td>
<td>5 Panel</td>
<td>______</td>
<td>________</td>
</tr>
</tbody>
</table>
IV. HEALTH CONDITIONS:

With respect to the attached job description, please specify conditions identified by your examination, which will prevent the individual from performing a particular job requirement – please note the job requirement and the manner in which the condition will prevent her/him from performing it.

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

V. RECOMMENDATION:

Based on the results of your examination, please state whether this individual is recommended for employment in the position described in the attached job description. If you give a conditional recommendation or recommend against employment, please state the specific reasons for that recommendation.

I have examined the above name applicant and recommend employment in the position described in the attached job description.

__________________________________ _____________________________
Physician’s Signature    Date

I have examined the above named applicant and am at this time unable to recommend employment in the position described in the attached job description.

__________________________________ ______________________________
Physician’s Signature    Date

COMMENTS:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

(Please Print the Following)

Physician’s Name: _______________________________
Physician’s Address: ____________________________
Physician’s Phone Number: ________________________

Revised 01/19