ALTERNATIVE VEHICLE DRIVER
PHYSICAL EXAMINATION REPORT

School District of Holmen

Incomplete forms will be returned for completion.

Applicant Name	Drivers License Number	Date of Birth
Home Address / City / State / Zip		Phone Number

The following section is to be completed by the Applicant and the Health Care Professional.

Section A Yes	Section A No	APPLICANT: Complete Section A / HEALTH CARE PROFESSIONAL: Complete Section B	Section B Yes	Section B No
		Alcohol or other drug abuse or dependency within the past 12 months		
		Alcohol or other drug abuse or dependency within the past 12 - 24 months not controlled by treatment		
		Neuro/Muscular disease, e.g., ALS, MS, Head Trauma		
		Diabetes or elevated blood sugar controlled by: _______Diet _______ Pills _______Insulin		
		Heart disease or heart attack, stroke, other cardiovascular condition		
		Heart surgery (valve replacement/bypass, angioplasty, pacemaker, AICD) Date ______________		
		Pulmonary disease or condition, positive TB communicable form, emphysema, COPD		
		Required oxygen use		
		Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring		
		Loss of body control, or altered consciousness Date ______________		
		Seizures, epilepsy Date of last episode ______________		
		Kidney disease, dialysis		
		Blood pressure over 180/105 (**If Yes**, provide 3 BP readings taken over a 2 week period, separated by at least 1 day)		
		Mental/emotional condition(s)		
		Missing or impaired hand, arm, foot, leg		
N/A	N/A	Inability to hear instructions given in normal conversational tone ☐ Corrected by hearing aid		
N/A	N/A	Any medication that would interfere with the safe operation of a vehicle		

Applicant: Complete the information below

For any YES answers, indicate onset date, diagnosis and any current limitations in the space provided below. List all medications (including over-the-counter medications) used regularly or recently.

I certify that the answers and statements made on this report are true and correct. I authorize the examining health care professional to release full details of an examination upon request to the School District of Holmen.

Applicant Signature **Date**

Health Care Professional: Complete the information below

For any YES answers above, indicate onset date, diagnosis and any current limitations. List all medications (including over-the-counter medications) used regularly or recently. Please use the back of this form for additional comments, if needed.

Would you recommend an additional medical evaluation?

Additional Comments:

This report must be based on an examination that was conducted in the past 12 months. I certify that I have examined this applicant and that I am licensece to practice _________________________ (MD, DO, PA-C, APNP, DC).

Practioner Name (Print)	**Patient Examination Date**	**Office Phone Number**

	Medical License Number	**National Registry Number - Chiropractor Only**
X	☐☐☐☐☐-☐☐☐	☐☐☐☐-☐☐☐☐- ☐☐

Authorized Signature

Form Updated: 6/1/2023