UCCM ANISHNAABE POLICE SERVICE EMPLOYMENT

VISION REPORT

APPLICANT NAME: _____

REACTION	ACCOM.		LIGHT	
PUPILS	EQUAL		UNEQUAL	
FUNDI				
FIELDS OF VISION				
COLOUR (TEST USED)				
WITHOUT GLASSES	NEAR		FAR	
WITH GLASSES	RIGHT	LEFT	RIGHT	LEFT
	RIGHT	LEFT	RIGHT	LEFT

OTHER CONDITIONS OR COMMENTS

_____

_____

_____

PARTICULARS OF EXAMINER

NAME ADDRESS PHONE _____

QUALIFICATIONS _____

_____

SIGNATURE _____

UCCM ANISHNAABE POLICE SERVICE
EMPLOYMENT

HEALTH EXAMINATION REPORT

CONSENT

I,_____, hereby consent to the release of the information gathered in respect of this medical examination to the Anishinabek Police Servcie to be used for the purpose of assisting in determining suitability for employment.

Position Applied For	**Today's Date:** **Year _____ Month _____ Day _____**
Sex: ☐ **Male** ☐ **Female**	**Date of Birth:** **Year _____ Month _____ Day___**
Surname:	**Given Names:**
Address **City/Town** **Postal Code** **Telephone**	
Family Doctor **Address** **Telephone**	

Date: _____

Witness: _____ Signature: _____

Personal History

Spouse

Children (Number and State of Health)

Military Services ☐ Yes ☐ No Disability Pension ☐ Yes ☐ No

Immunization

TB Skin	Yes / No	Date of Last Test	Result	Chest x-ray	Yes / No	Date of Last One	Reason
	☐ / ☐				☐ / ☐		

Past Health History

Past Illness (including Childhood Illnesses, High Blood Pressure, Heart Disease, Diabetes, Thyroid Disease, Cancer)

Operations

Accidents

Hospitalizations

Allergies

Medications (Prescription - Other)

Habits

	Yes	No	Quantity
Cigarettes - Tobacco			
Hard Drugs			
Alcohol			
Coffee/Tea			

Family History

	Mother	Father	Other		Mother	Father	Other		Mother	Father	Other
Tuberculosis				Epilepsy				Skin Disorder			
Diabetes				Blood Disorders				Kidney Diseases			
Cancer				Asthma				High Blood Pressure			
Nervous Disorders				Hay Fever				Heart Disease			
Glaucoma				Alcoholism							

Other Details : (include other Diseases)

Health History (Continued) Functional Enquiry

A. Current Health Status ☐ Good or ☐ Bad

B. Are you suffering from or under treatment for any disease now? ☐ Yes ☐ No Name: _____

C. Do you have a pre-existing illness or injury that would prevent you from doing the essential duties of the job?

☐ Yes

☐ No

D. Do you now or have you ever suffered from any of the following

	Yes	No		Yes	No		Yes	No
Recent Change in Weight			Allergy to Drugs			Constipation - Diarrhea		
Recent Fatigue or Weakness			Anemia - Blood Conditions			Bloody or Black Bowel Movement		
Head Injury or Concussion			Breast Problems - Lumps			Haemorrhoids		
Fainting Spells or Dizziness			Night Sweats			Hernia or Rupture		
Epilepsy or Convulsions			Chronic Cough			Kidney or Bladder Trouble		
Frequent Headaches			Coughing - Mucus or Blood			Infections, or Stones		
Migraine			Lung Disease i.e.. TB, Pneumonia			Frequently Passing Water		
Ear Aches or Infections			Bronchitis, Emphysema			Pain - Burning Discharge		
Ear Noises or Deafness			Shortness of Breath			Urine - Bloody or Discolored		
Eye Irritation or Infection			Palpitations			Neck or Back injury or Pain		
Serious Eye Problems			Heart Trouble			Low Back Pain		
Vision Problems			Chest Pain - Pressure - Tightness			Varicose Veins - Phlebitis		
Nose or Throat Problems			Swelling of the Ankles			Numbness or Tingling		
Frequent Nose Bleeds			Rheumatic or Scarlet Fever			Rheumatism or Arthritis		
Sinus Trouble			Ulcers - Stomach Trouble			Other Joint or Muscle Problems		
Frequent Colds/Sore Throats			Indigestion - Nausea - Vomiting			Foot Problems		
Tooth or Gum Trouble			Vomiting Blood			Problems Sleeping		
Skin Rashes; Itchiness,			Liver Trouble - Jaundice			Nervous Trouble Breakdowns		
Skin - Moles - Tumor			Abdominal Pain			Menstrual Problems		
Hives - Hay Fever Asthma			Bowel Trouble			Have You Any Restriction on Physical Activity		

Explain "yes" answers

PHYSICIAN'S EXAMINATION

SURNAME **GIVEN NAME** **DATE**

GENERAL	Appearance		LABORATORY	Haemoglobin	
	Mental Status			Urine (Dip Stick)	Alb. Sugar
	Height	cm		Other Tests If Indicated	
	Weight	Usual Present			
	T.P.R.	T. P. R.	CHEST X-RAY	Date	
EYES	Reaction	Accom. Light	Pulmonary Function Tests (if indicated) Date		
	Pupils	Equal Unequal			
	Fundi		ECG (if appropriate)		
	Fields of Vision				
VISION	Color (Test Used)		Health Education (Specify)		
		Near Far			
	Without Glasses	R / L / R / L /			
	With Glasses	R / L / R / L /	Immunization Given (Specify)		
EARS	Hearing	R L			
	Drums	R L	THIS SPACE FOR ADDITIONAL INFORMATION AND REMARKS		
	Other	R L			
MOUTH TONGUE	Gums				
	Dental/Hygiene				
	Other				
THROAT-TONSILS					
NECK	Movement				
	Pain-Tenderness				
	Other				
THYROID					
LYMPH NODES					
BREASTS					
HEART	Size				
	Rhythm				
	Murmurs				
	Carolid Bruits				
BLOOD PRESSURE	Before Exercise				
EXCERISE AS APPROPRIATE (ESPECIALLY POLICE APPLICANTS)	Heart Rate Resting				
	After Exercise				
	1 Minuter After				
	2 Minutes After				
	Exercise (e.g. 20 step ups)	Time EGG.			
CHEST	Type				
	Resonance				
	Activenitious Sounds				
ABDOMEN	Appearance - Scars				
	Tenderness				
	Masses/Organs				
	Bowel Sounds				
HERNIA	Inguinal				
	Femoral				
	Other		**Impressions** **Healthy**		**Health Problems**
RECTAL					
HAEMMORHOIDS			**Fit For Job** ☐ **Fit with limitations** ☐ **Unfit** ☐		
PROSTATE/PELVIC	If Appropriate				
DEFORMITIES			**Please describe problems/limitations**		
EXTREMITIES	Arms/Hands				
	Legs/Feet				
	Varicose Veins	R L			
JOINTS	Upper (Espec. Shoulders)		Examining Physician (Please Print Name)	**Phone**	
	Lower (Espec. Knees)				
SKIN			**Address**		
SPINE	Mobility				
	Pain/Tenagmes				
	Deformity				
NERVOUS SYSTEM	General		**SIGNATURE**		
	Tendon Reflexes	R L			