SCHOOL DISTRICT OF WAUPACA

CODE: 541.61R1

SERIES 700 SUPPORT SERVICES

BUS DRIVER MEDICAL EXAMINATION FORM

See following form.

ADOPTED: REVISED:

REVIEWED: 121493

LEGAL REFERENCE:

CONTRACT REFERENCE:

CROSS REFERENCE:

School District of Waupaca is an Equal Opportunity Employer $\qquad \qquad \text{Page 1 of 1} \\$

MEDICAL EXAMINATION REPORT for Commercial Driver Licensing Endorsements MV3030B 892

	Operator's License Number				Wisconsin Department of Transportation Medical/Alcohol Review Section P.O. Box 7918, Madison, WI 53707-7918				
plicant's Name			Date of Birth	Area Code & Phone Number					
Street Address		City		Zip Code	Application Held At:				
Date	Driver's License Examiner	Number	Application For Spec	cial Endorsement	S - School Bus				
Employer's Name	300								
Employer's Street Addres	ss	City	State	Zip Code	Area Code & Phone Number				
Drior to consideration to consideration to consideration to consideration to consideration the person(s) yet of the person of th	eck No or Yes. Explain all Yeu experienced or been treated or other drug abuse or depisease? Insion (high blood pressure)? It is essel disease or disorder of or brain injury? It is mellitus or other metabolication or other physical conditions sease or breathing problems	ill not be made information. Implete Section rephysician for A: TO BE CO es answers on ed for: Dendency during their than various e past 12 most disease such ion which affer (asthma, emphor loss of book information in the control of the control o	de available to the pure Payment for the med "A." recompletion of Second Payment for the med pure Payment for the med pure Payment BY APPLI in lines below. In the past 2 years? The past 2 yea	pituitary insuffinds, legs or fiberculosis, etc.	rour written authorization on and preparation of the ficiency, etc.?				
		241							
	, , , ,								
1. Describe other illn	nesses, injuries or disabilities								
12. Are you taking and □ No □ Yes - Pro	y medication? ovide name(s) of medication(s	s), frequency a	and reason						
					and the second s				
				17	2 2				

(Signature of Applicant)

(Date)

SECTION B: TO BE COMPLETED BY PHYSICIAN

Note to Examining Physician: This examination report is required of a person applying for a commercial driver license. The applicant must present this completed form to a driver license examiner. Any charges or fees are the responsibility of the applicant. The Secretary of the Department of Transportation is, by statute, responsible for the decision of driver's licensing. Your report will be advisory in determining eligibility. A copy of Trans. 112, Wis. Admin. Code, which details the medical standards for licensing, is available upon request.

This report must be based on an examination conducted	within the seed	00 1	ng, is available		st.
Blood Pressure Height Weight	within the past	90 days.	Blood F	Pressure	Reading Date
If blood pressure is above 150 systolic or 90 diastolic, ple readings taken within the past 90 days, and taken at least 24 Any reading over 180/105 disqualifies the driver for either	ase provide two 4 hours apart er an S or P en	(2) addition	nal		
Please answer all of the questions. Explain all Yes answer	rs on lines hale		•		
10 your knowledge, has the applicant experience	d or been troate	d 600			
. Accord of other drug abuse or dependency with	in the past 12 m	ontho?			
2. Alcohol of other drug abuse or dependency within	in the past 12-2	A months?	•		
22 if les to question 2, is applicant's condition of	controlled by trea	itment?			to all
C. Hypertension:	100				. 13
angina pectoris, coronary ins	sufficiency, throm	posis or a	ny other care	diovascular	disease or
condition known to be accompanied by syncope, 5. Mental/emotional disease or disorder within the particles of the condition	DVCDDDD COllabe	e, or conge	estive cardiad	failure?	a re-
5a. Was the applicant involuntarily hospitalized or i	ast 12 months?			Ef.	
5b. Is applicant taking psychotropic medication?	institutionalized?				
6. Diabetes Mellitus or any other metabolic disorder	which may affect	t driving?			
of is applicant taking medication to control this or	ondition?			1	
☐ /. Kneumatic, arthritic, orthopedic, muscular, neuromu	scular or vascula	r disease c	or disorder?		
- is the congoing treatment for this condition w	which may impair	d-i:7			
o. hespiratory disease or disorder (must be free from	m tuberculosis in	a commun	nicable form	as determin	ned by a
☐ 9. Amputation or loss of use of hands or feet within☐ ☐ 10. Stroke or brain injury?	n the past 2 yea	rs?			
11. Episode(s) of altered consciousness or loss of b					
11a If yes, please give date of last episode	odily control?				
☐ ☐ 12. Is this person taking any medication (see other si	ide) that would in			AL .	1
	2 - 20-2-8		ar sare open	ation of a	school bus?
					water content of the content of
91					
					4
			_		25
AIO. NO.					
NO YES					(S.M.)
Are corrective lenses required while driving?		Vi-			
Does client have programme.	Color	Visual Acuity	Without RX	With RX	Temporal Field of Vision
If we progressive eye disease or cataracts?		Right			1 1 1 1 1 1 1 1 1 1
Describe Describe	☐ Normal	Eye			
		Left			
	☐ Deficient	Eye			
Langue City Committee Comm	в в и				
I certify that I have examined this applicant and	that				
I am licensed to practice	in Wiscor	nsin.			
Name of Physician (Please Print)					(\
			Medical Lice	nse Number	
Signature of Reporting Physician	Date of Examina	ation	1000		
X			Area Code &	Office Phon	e #