



Do NOT write in this space.

DEPARTMENT OF EDUCATION
PHYSICAL EXAM FORM FOR SCHOOL BUS DRIVER LICENSE ENDORSEMENT



Refer to the **INSTRUCTION SHEET** to fill out this form and provide it to your physician at the time of your physical. Available at <http://maine.gov/education/const/pt007.htm>

APPLICANTS APPLYING FOR SCHOOL BUS DRIVER LICENSE ENDORSEMENT FOR THE FIRST TIME- Your physical must be conducted and the form must be completed, signed and dated by examining physician no more than three (3) months prior to submission of the form to the Bureau of Motor Vehicle.

SECTION 1 – Applicant Information and Authorization – To be filled out by the applicant. PRINT CLEARLY

Applicant's Full Name		Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Maine 7-Digit Driver License #
Street/P.O. Box		City	State	Zip Code

Phone: Work _____ Home _____ Email: _____

School unit /contractor where you will be working as a bus driver (if known) _____

APPLICANT - Check appropriate type of physical exam below and follow the instructions provided.

Physical for first-time applicants for school bus driver license endorsement. Submit this completed form with your other paperwork and fees to the Bureau of Motor Vehicle, 29 State House Station, Augusta, ME 04333-0029

Annual Physical. Submit this completed form to your employer for review and retention in your employment file. DO NOT send it to the Bureau of Motor Vehicle or the Department of Education

Authorization

I hereby authorize the release of my medical history to the Bureau of Motor Vehicle, the Department of Education, and my employer for the purpose of verifying my medical eligibility for a school bus driver license endorsement

Applicant's Signature: _____ Date _____
APPLICANT MUST SIGN AND DATE

SECTION 2 – Medical History - Does applicant have or has he/she ever had any of the following:

Seizures/epilepsy?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Heart trouble?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Fainting spells?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Tuberculosis?	YES <input type="checkbox"/> NO <input type="checkbox"/>
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If YES to any of the four above, list onset date, diagnosis, treatment, and any current limitation(s). List all medications (including OTC's) used regularly along with any side effects experienced. Also, indicate if the illness/condition is under good control. **PLEASE USE LAYMAN'S TERMS AND PRINT CLEARLY.** Attach an additional sheet if necessary.

Diabetes? YES NO If yes, check all boxes that apply and follow instructions as shown:

Type 2 **Controlled by:** diet exercise oral meds -- No additional information needed for Type 2. Go to Section 3.

Type 1 **Insulin controlled?** Yes No – If Yes, see **Federal Regulations and Criteria** and complete a **Certification form**. See **Instruction Sheet** the applicant should provide; or available online at: <http://www.maine.gov/education/const/pt007.htm>

SECTION 3 – Vision – May be performed by either a licensed physician or a licensed optometrist.

VISUAL ACUITY	UNCORRECTED	CORRECTED	HORIZONTAL FIELD OF VISION	DEPTH PERCEPTION
Right Eye	20 / _____	20 / _____	Must be minimum 70° in horizontal meridian in each eye and total of at least 140° in both eyes.	Must be ≤ 40 seconds of arc
Left Eye	20 / _____	20 / _____		
Both Eyes	20 / _____	20 / _____		

Corrective Lenses - Applicant meets visual acuity requirement **only** when wearing corrective lenses? Yes No

Color perception –Recognizes traffic signals showing red, green & amber? Yes No

Vision muscular anomalies _____

SECTION 4 – Hearing – use one of the two methods of testing below

Method 1 - Record distance from individual at which forced whispered voice can first be heard.

Right Ear

Left Ear

Was a hearing aid used (Method 1)?

Yes No

Method 2 – Using an audiometer, record hearing loss in decibels according to ANSI ZZ24.5-1951 (fill in below).

Right	500 Hz _____	1000 Hz _____	2000 Hz _____	Average _____	Meets Standard? Yes <input type="checkbox"/> No <input type="checkbox"/>
	500 Hz _____	1000 Hz _____	2000 Hz _____	Average _____	Meets Standard? Yes <input type="checkbox"/> No <input type="checkbox"/>
Left	500 Hz _____	1000 Hz _____	2000 Hz _____	Average _____	Meets Standard? Yes <input type="checkbox"/> No <input type="checkbox"/>

Was a hearing aid required to meet the standard (Method 2)? Yes No

SECTION 5 – Blood Pressure / Pulse Rate

BP	_____ / _____ BP must be ≤ 160 systolic over ≤ 90 diastolic	Arteries:	Sclerosis _____ Pulsations _____
Pulse:	Beats/min. _____	Regular <input type="checkbox"/> Irregular <input type="checkbox"/>	Enlargement indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Heart sounds at apex murmur: _____

SECTION 6 – General

Height: _____ ft _____ in	Weight: _____ lbs	Lungs:	Rales:	Breath sounds:
Chest X-Rays: (See NOTE below)				
Deformities of extremities:				
Routine office urinalysis:				
Evidence of:	Infectious disease <input type="checkbox"/>	Drug addiction <input type="checkbox"/>	Mental disability <input type="checkbox"/>	Emotional instability <input type="checkbox"/>
Physician comments regarding any abnormal ailment, disease, defect, or condition found during the physical examination.	Please print legibly and use layman's terms. Attach an additional sheet if necessary.			

SECTION 7 - Certification

IMPORTANT NOTE TO PHYSICIAN: A school bus driver does more than simply drive the bus. There are other safety sensitive performance responsibilities such as student management and incident control; bus evacuation with ambulatory students; bus evacuation with injured students and/or students with special needs who require additional assistance and/or lifting; bus pre-trip and post-trip inspections; bus cleaning (including lights and windows); and so on. Please keep this in mind when making a determination as to the applicant's physical ability to meet those responsibilities.

After examination, I find the applicant, [name] _____ IS IS NOT free from ailment, disease, or defect that might affect his/her ability to safely perform the duties of a school bus driver.

Physician's Signature	Date of Exam
Physician's Name (printed)	Phone
Physician's complete mailing address	

NOTE: Chest x-ray or intradermal tuberculin test is required only if possible lung disease is indicated. Tuberculin test may be substituted.