

HEALTH EXAMINATION CERTIFICATE

1. *Name:* _____ *Age:* _____ *Sex:* _____
2. *Address:* _____
3. *Blood Pressure:* _____ *Weight:* _____ *Height:* _____
4. *Skin:* (record any evidence of disease) _____
5. *Vision:* Without glasses: R:20/ _____ L:20/ _____ With glasses: R:20/ _____ L: 20/ _____
6. *Hearing:* Is there any obvious hearing disorder? No _____ if yes, please describe

7. *Mouth, Nose, Throat:* (record any evidence of disease or presence of speech defect)

8. *Heart and Lungs:* (state whether individual can undergo normal activity)

9. *Tuberculosis:* Tuberculin skin test: (record date and findings)

10. *Immunization:* Has individual been immunized against tetanus/diphtheria with adult-type tetanus/diphtheria (Td) toxoids within past ten years? Yes _____ No _____
Rubella: Immunization _____ or Blood Test indicating immunity _____
11. *Abdomen:* (record any abnormality found, including hernia)

12. *Genito-Urinary:* (record any abnormalities found, result of urinalysis, and if necessary microscopic examination of discharge)

13. *Nervous and Mental:* (record any defects found)

14. *Additional Findings:* _____
15. *Recommendations:*

This is to certify that an examination of the above named person shows the results indicated, and that he/she _____ is _____ is not free of tuberculosis or other communicable disease, or any disease, physical or mental, which will impair the ability of this person to perform his/her duties.

Date: _____ Signature of Physician: _____ M.D.