

STUDENT HEALTH CERTIFICATION



Student's Name _____ Age _____

PHYSICAL EXAMINATION

Height _____ Weight _____ B/P _____

| | Normal | Abnormal | Explain |
|---------|--------------------------|--------------------------|---------|
| HCT/CBC | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| TB Test | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| VDRL | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

MEDICAL HISTORY

| | Yes | No | Explain |
|------------------|--------------------------|--------------------------|---------|
| Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Seizures | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Back Injury | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Lung Disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Hypertension | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Spinal Disorders | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Mental Disorders | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Disabilities | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Physician's Signature _____ Date ____/____/____

**CHRISTIAN
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EST. 1949

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