

HEALTH CERTIFICATE

NAME OF APPLICANT: _____

WHAT SERIOUS ILLNESS HAS THE APPLICANT HAD: _____

WHAT OPERATIONS HAS THE APPLICANT HAD: _____

IS THERE A FAMILY HISTORY OF TUBERCULOSIS: _____

HAS THE APPLICANT HAD RHEUMATIC FEVER: _____ CHOLERA: _____

IS SHE/HE SUBJECT TO TONSILITIS: _____ SINUSITIS: _____

IS SHE/HE SUBJECT TO FREQUENT RESPIRATORY INFECTION: _____ OTITIS: _____

IS SHE/HE SUBJECT TO DIGESTIVE DISEASES: _____

IS THERE ANY HISTORY (EITHER RECENT OR REMOTE) OF ASTHMA, OR ANY OTHER ALLERGIES:

DOES SHE/HE SUFFER FROM ANY PELVIC DISORDERS: _____ MENSTRUAL DISORDERS: _____

HAS SHE/HE EVER CONSULTED A PHYSICIAN ABOUT ANY NERVOUS DISORDERS: _____

DATE AND LENGTH OF LAST VACATION: _____

PHYSICAL EXAMINATION

AGE: _____ HEIGHT: _____ WEIGHT: _____ B.P: _____

EYES: _____ DATE OF LAST EXAM (IF APPLICANT WEARS GLASSES) _____

NOSE: _____ EARS: _____ THROAT: _____ TEETH: _____

DATE OF LAST DENTAL EXAMINATION: _____ HEART: _____

ABDOMEN: _____ CHEST X-RAY _____ (ENCLOSE FULL-SIZE FILM & REPORT)

MANTOUX: _____ DATE: _____ R.B.C: _____ H.B: _____

VERIFY IMMUNIZATION STATUS: _____

THE APPLICANT IS SEEKING EMPLOYMENT AS A (TICK AS APPLICABLE): NURSE DOCTOR OTHER (PLEASE SPECIFY) _____

IS THE APPLICANT MEDICALLY FIT TO ASSUME EMPLOYMENT IN THE REFERENCED CAPACITY _____

DATE: _____

SIGNED: _____

ADDRESS: _____
