ADULT PHYSICAL EXAMINATION

COMPLETE AND RETURN TO:

School Name and Address

STUDENT'S NAME

ADDRESS

PHONE

EMERGENCY NUMBER

CONTACT PERSON

TRADE/PROGRAM

DATE OF BIRTH

SOCIAL SECURITY NO

PART 1
IMMUNIZATION HISTORY

Vaccine Type	Disease	Date	Immunization	Date
*DPT (DT)				
TB (ADULT)				
ORAL POLIO				
*MEASLES(RUBEOLA)				
*GERMAN MEASLES(RUBELLA)				
CHICKEN POX				
HEPATITIS				

Immunization contra-indicated for _____ Medical _____ Religious Reason.
***I certify that this applicant has the immunization required.**

Signature_____ Date_____

Acceptable Signature: Physician, Physician's Assistant or an APRN.