ANNUAL PHYSICAL EXAM

Name:		DOB:	
Address:			
Height:	Weight:	Sex:	BP:

Laborary Results:

TUBERCULIN TEST – PPD	DATE ADMINISTERED:		READ:	RESULTS	
²ND STEP IF POSITIVE	DATE ADMINISTERED:		READ:	RESULTS	
CHEST X-RAY	DATE:			RESULTS	
RUBELLA TITER	IMMUNIZATION DATE:			RESULTS	
RUBEOLA TITER	IMMUNIZATION DATE:			RESULTS	
MUMPS TITER	IMMUNIZATION DATE:			RESULTS	
VARICELLA TITER	IMMUNIZATION DATE:			RESULTS	
TETANUS	IMMUNIZATION DATE:				
DIPHTHERIA	IMMUNIZATION DATE:				
POLIO	IMMUNIZATION DATE:				

HEPATITISIB SCREENING	VACCINE 1 DATE		VACCINE 2 DATE	VACCINE 3 DATE	
FLU SHOT	DATE ADMINISTERED				

RECOMMENDATION:

I CERTIFY THAT I HAVE EXAMINED THE ABOVE NAMED INDIVIDUAL AND HAVE FOUND HIS / HER HEALTH TO BE SATISFACTORY TO PERFORM THE DUTIES REQUIRED AS A HEALTHCARE CLINICIAN.

PHYSICIAN'S SIGNATURE		DATE	
PHYSICIAN'SNAME		LICENSE #	

PHYSICIAN'S!STAMP: