

Health Certificate

Name of applicant	Sex	Date of birth	Age
Address			
Height	cm	Weight	kg
Eyesight	R : (, corrected)	L : (, corrected)	
Color vision	Normal / Abnormal ()		
Hearing	R : Normal / Hypacusis ()		L : Normal / Hypacusis ()
Blood pressure	/ mmHg		
Chronic illnesses			
Past medical/surgical history			
Allergies/Medications			
Family history			
Physical Examination			
Urinalysis	Protein ()	Glucose ()	
Chest X-ray	(Direct / Indirect)		Date taken :

Immunization

	Date		Date
Hepatitis B #1		Measles	
Hepatitis B #2		Mumps	
Hepatitis B #3		Rubella	
Polio		DPT	
Varicella			

Name of the Hospital :

Address :

Physician :

Signature

Date