ANNUAL PHYSICAL EXAM

NAME:____DATE OF EXAM: ________________________

ADDRESS:____DATE OF BIRTH: ________________________

HEIGHT:________________ WEIGHT:_______________ SEX:________________ BP: ________________

LABORATORY 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: ___________________		
HEPATITIS B 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'S NAME____LICENSE # ________________________

PHYSICIAN'S STAMP:

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