Department of Education
RAPHAEL O. WHEATLEY SKILL CENTER
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HEALTH CERTIFICATE

SECTION I – TO BE COMPLETED BY PATIENT

I. Name : _____ *(Please Print)*

Birth Date: _____ Sex: _____

Address: _____

Home Phone: ( ) _____ Cell #: ( ) _____ Work #: ( ) _____

SECTION II: TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination: _____

Results of physical examination: Normal ( ) Yes ( ) No

Height: _____ Weight: _____

I. **GENERAL APPEARANCE:** *(Place a check mark (√) next to those that apply)*

Nutrition _____ Nose _____ Lungs _____ Malformation _____

Head _____ Throat _____ Abdomen _____ Chest _____

Eyes _____ Heart _____ Genitalia _____ Tonsils _____

Ears _____ Adenoids _____ Skin _____ Teeth _____

II. **IMMUNIZATIONS:** Patient should present Immunization Record to make sure up-to-date.

Hepatitis B: Dates (1) _____ (2) _____ (3) _____

MMR: Measles _____ Rubella _____ Mumps _____ Tetanus _____

Tuberculosis Test (TB): Type _____ Date _____ Results _____ Other _____

(Current PPD, read & dated within the past six months)

III. **HISTORY OF DISEASES/PERSONAL HEALTH INFORMATION:**

Diabetes _____ Heart Disease _____ Allergies _____

Asthma _____ Hypertension _____ Measles _____

Epilepsy _____ Strep Infection _____ Infectious Mononucleosis _____

Mumps _____ Chicken Pox _____ Other _____

Any other existing allergies/sensitivities (please indicate) _____

Laboratory Findings: *(Optional)*

Tuberculin Test _____ Hematocrit _____ Urinalysis _____

Stool _____ Sickle Cell _____ Hemoglobin _____

( ) *I have examined the patient listed above and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all school activities/classes, unless noted above.*

Name of Health Care Provider	Address of Health Care Provider
Signature/Date	Phone Number of Health Care Provider