J & J HEALTHCARE INSTITUTE

HEALTH CERTIFICATION FORM

STUDENT INFORMATION
Last name: _____ First: _____ Middle Name: _____
Age: _____ Sex: _____ Date Examined: _____

MEDICAL INFORMATION:
(To be completed by a physician)

Have you examine the patient for any illness? Y___ No___

If so
Explain_____
_____

Has the applicant been treated for any of the following?

Tuberculosis ___ Diabetes___ Heart Disease___ Anemia___ Migraine___ Asthma___
Rheumatic Fever___ Epilepsy___ Thyroid Disorder____

If so
Explain_____
_____-_____

Does the applicant have any handicap which may interfere with his/her studies? Y___ N___

Has the applicant received treatment or been admitted to a hospital for mental disorders Y__ N__

If so
Explain_____
_____

Does the applicant have any of the abnormalities in the following?

Skin Lymphomas Head Ears Nose & Sinus Spine Chest Heart
Abdomen Vascular System Endocrine System Neurological System

If so
Explain_____
_____

VITAL SIGNS

Temperature _____ Blood Pleasure _____

Pulse _____ Breathing _____

Does the applicant have any vision problems? Y_____ N_____

If so
Explain_____
_____

Have the applicant receive all immunization? Y____ N_____

After examining the applicant, did you find any significant medical condition or disability that would limit his/her participation in academic and / or physical activities? Y___ N___

If so, please specify
_____
_____
_____
_____

PHYSICIAN INFORMATION

Name: _____

Address_____

Phone: _____

Signature _____ Date_____