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Health Clearance Form

Date: ____________________

Patient Name: _________________________

Date of Physical Examination: ____________________

I attest that I have examined the about named patient and find he/she to be in good physical health, free of communicable diseases without pre-existing back in injuries. He/She is free to work without any restrictions at this time.

Physician Signature:______________________________________Date: _____________

Physician Name: ____

Address: ____

Telephone: ____

Immunization History

MMR vaccine #1 ________________ vaccine #2___________________

Titer Date and Results ____

Tdap Date: vaccine ____

Varicella vaccine date:____________________Titer date/results_________________

Hepatitis B vaccine dates #1_________________
#2_________________
#3_________________

Hepatitis B Titer Date and Results _______________________________________

Dates and Results PPD #1___________________ #2________________________

Chest X Ray Date and Results
(If applicable) ____