# Health Certificate Form Online

## Applicant Information

- **Name:** _____
- **Date of Birth:** _____
- **Contact Email:** _____
- **Phone Number:** _____

## Medical Information

- **Date of Last Physical Exam:** _____
- **Primary Physician:** _____
- **Physician's Contact Information:** _____

## Current Health Status

- **Are you currently under any medication? Yes ☐ No ☐**
- **Please list any known allergies:** _____

## Health History

| Year | Condition | Treatment | Current Status |
|---|---|---|---|
| ____ | _____ | _____ | _____ |
| ____ | _____ | _____ | _____ |
| ____ | _____ | _____ | _____ |
| ____ | _____ | _____ | _____ |

| | | | |
|---|---|---|---|
| ***(Continue this table as needed)*** | | | |

## Declaration

- I declare that the information provided is true and accurate to the best of my knowledge.

**Applicant's Signature: _____ Date: _____**