Health Certificate Form PDF

Personal Information

- **Full Name:** _____
- **Date of Birth (MM/DD/YYYY):** _____
- **Gender:** Male ☐ Female ☐ Other ☐
- **Contact Number:** _____
- **Email Address:** _____

Medical Examination Details

- **Date of Examination (MM/DD/YYYY):** _____
- **Physician's Name:** _____
- **License Number:** _____

Health Assessment

- **Blood Pressure (mmHg):** _____
- **Heart Rate (bpm):** _____
- **Height (cm):** _____ **Weight (kg):** _____
- **Vision Test:** Pass ☐ Fail ☐
- **Hearing Test:** Pass ☐ Fail ☐

Vaccination Record

Vaccine Name	Date Administered	Lot Number	Next Due Date
_____	_____	_____	_____
_____	_____	_____	_____

_____	_____	_____	_____
_____	_____	_____	_____
(Continue this table as needed)			

Physician's Statement

- **Findings:**

_____

_____

_____

- **Certification:**
  I hereby certify that the above-named individual has undergone the necessary medical examination and is found to be in [ ] Good Health [ ] Fair Health [ ] Poor Health.

Physician's Signature: _____ Date: _____