



# Health Certificate & Vaccination

Date \_\_\_\_\_

**Previous history of immunization:**

Vaccine	Full course of immunization		Comments
	YES	NO	
DTP			
MMR			
OPV			
Hepatitis vaccine			Please indicates dates*

\*1st Shot \_\_\_\_\_, 2nd Shot \_\_\_\_\_, 3rd Shot \_\_\_\_\_

**After thorough physical examination and evaluation of laboratory results which includes:**

VDRL: \_\_\_\_\_ non reactive      \_\_\_\_\_ Reactive  
 Comments:

PPD: \_\_\_\_\_ negative      \_\_\_\_\_ positive  
 Comments:

I \_\_\_\_\_ hereby certify that  
 (name of examining physician)

Mr. (Ms.) \_\_\_\_\_ is physically and mentally fit \_\_\_\_\_ NOT fit  
 \_\_\_\_\_ to be enrolled as a student in the health related program he is applying to.

Physician name and address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

State license: \_\_\_\_\_

Signature of examining physician \_\_\_\_\_