PHYSICIANS CERTIFICATE FOR SCHOOL PERSONNEL

Name____Date of Birth________________

Address____Sex_____Marital Status__________

Medical History____

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GeneralDevelopment__________________________________Ht.___________Wt.____________

Eyes: Vision Right___________________________Vision Left______________________________

Hearing: Right Ear___________________________Left Ear________________________________

Heart: Rate___________Blood Pressure____________Rhythm___________Murmur___________

Lungs: ____

T.B. Skin Test or Chest X-Ray____

Skin____

Neuromuscular Abnormalities____

Mental and Emotional Condition:____

Remarks:____

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CERTIFICATION

This is to certify that I, ____a licensed physician, County Of ____________________________, State of Tennessee, have on this date___________ Examined and found applicant to be free from any ailment, disease, or defect that might affect his or her employment in a school system