HEALTH CERTIFICATE

Grundy Center Community School District

(You are responsible for payment of physician's fee.)

To be completed by employee:

Name_____ Birth Date_____ Sex___
Last First Middle

Address_____ Phone_____

Personal Physician _____

Address _____ Phone_____

To be completed by physician:

This is to certify that _____has been examined by the undersigned physician and his/her general and specific status of health are as circled below:

General Health	Poor	Fair	Good	Excellent
Heart and Circulation.	Poor	Fair	Good	Excellent
Nervous Condition.	Poor	Fair	Good	Excellent
Pulmonary Condition.	Poor	Fair	Good	Excellent

Remarks_____

_____

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_____

This is to certify that the above named person is physically qualified to perform the services of teacher in this school.

Date _____ Signature of Examining Physician_____

Printed Name of Physician _____

Address _____
