Statement of Health	
Employee Name	Date
Date of Birth	Sex
Family Physician Name	Physician Phone
Have you had any sprains, strains or pulled muscles in the past 12 months?	Have you been hospitalized in the past 12 Months?
List any allergies:	Do you have seasonal allergies that require medication?
Are you currently taking any non-prescription medications?	Do you cough, wheeze or have trouble breathing after activity?
Do you use any protective equipment (knee brace, back brace, etc.?)	Have you had problems with your vision? Do you wear glasses or contacts?
Are you free from communicable diseases?	Do you have any physical limitations or restrictions that would prevent you from clinical activities such as moving, lifting or transferring patients?
I certify that all information provided above is true and correct to the best of my knowledge. Signature _____ Date:_____	

Physical Information:			
Height	Weight	Pulse	Blood Pressure

Medical Evaluation: Normal or Abnormal Findings	
Eyes/ Ears/ Nose/ Throat	Neck
Back	Shoulder/ arm
Heart	Elbow/ Forearm
Pulse	Wrist/ Hand
Lungs	Hip/ Thigh
Abdomen	Knee/ Leg
Skin	Ankle/ Foot
Evaluation provided by: _____ Date: _____	

American Medical Personnel
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