Memorandum

Subject: Statement of Health and Immunization

Date: Revised 2007

Please indicate if you had; do you presently have; or are you under a physician's care for the following by placing a check (√) in the appropriate category.

Statement of Health

	YES	NO		YES	NO
Allergies	____	____	Tuberculosis	____	____
Asthma	____	____	High Blood Pressure	____	____
Back Pain	____	____	Operations	____	____
Chest Pain	____	____	Rheumatic Fever	____	____
Headaches	____	____	Other Illness(es)	____	____
Hearing Loss	____	____	Injuries Treated by a Doctor	____	____
Hernia	____	____			

If you answered **YES** to any of the above questions, please specify dates of occurrence and if any complications resulted from the described illness or injury.

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Statement of Immunization

____ I have received the complete Hepatitis B Vaccine series. Year: ____________

____ I have not received the complete Hepatitis B Vaccine Series.

____ I have received the complete Mumps, Measles and Rubella Series. Year: ____________

____ I have not received the complete Mumps, Measles and Rubella Series.

I hereby certify that the above information is **true and correct** to the best of my knowledge.

____________________	____________________	____________________
Name	Signature	Date
____________________	____________________	____________________
Witness's Name	Witness's Signature	Date