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MC HENRY, ILLINOIS 60050
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HEALTH QUESTIONNAIRE - PHYSICIAN'S STATEMENT

Applicant Name:_____
(Please print name)

Read each statement and indicate whether true or false.

_____ I do not have any pre-existing conditions; medical or physical which would prevent me from successfully performing the duties involved with the daily care and developmental growth of infants and/or young children.

_____ I am free from any communicable disease.

My general health condition is: please check one.

___ Excellent ___ Good ___ Fair ___ Poor

I am allergic to the following items:_____

_____

I request my physician and/or his representative to provide the information requested below and release them from any and all liability of any kind or nature for providing this information.

_____
Applicant's Name Date

. . . . . .

Submit to your physician for verification signature and return to Agency

I hereby certify,_____,is without any symptoms evidencing the existence of infections or communicable disease.

Physician's Name:

_____

_____
Physician's Address
City, State Zipcode

_____
Physician's Signature Date

_____
AMA Number