CERTIFICATE OF MEDICAL FITNESS

This is to certify that (name) _____

Has this day _____ been examined by me _____

The following are my findings:

1. Chest X-ray _____
2. Urine _____
3. Eyes _____

Does the student have any history of suffering from any of the following?

Asthma	Yes/No	TB	Yes/No
Hypertension	Yes/No	Hepatitis	Yes/No
Diabetes	Yes/No	Epilepsy	Yes/No
Migraine	Yes/No	Allergy	Yes/No
Kidney disease	Yes/No	Others	_____
			_____

Any other comments and recommendations by the medical officers

_____

_____

Signature of Medical Officer:

_____

Hospital Rubber Stamp