CERTIFICATE OF MEDICAL FITNESS

Student Name: _____

Date of Birth: _____ **Student ID #:** _____ **Gender:** _____

TO BE COMPLETED BY PHYSICIAN:

Please complete the following certification, sign, stamp and return to the student in a sealed envelope.

I certify that I have carefully examined _____. I certify that he/she is in good mental and physical health and is free from any communicable diseases or illnesses that may interfere with his/her studies including any activities outdoors.

Name of Physician: _____

Name of Medical Practice/Clinic: _____

Address: _____

_____

Telephone: _____

Signature: _____