PORT-OF-SPAIN CORPORATION
FOOD HANDLERS' MEDICAL EXAMINATION

Date: _____

Name: _____

Home Address: _____

Identification: /PP/ID# _____ Telephone Contact: _____

Sex: Male [ ] Female [ ] Date of Birth: _____

Name of Business: _____

Type of Business: _____

Address of Business: _____

Family History (tick where appropriate)

1.	Typhoid	Yes [ ]	No [ ]
2.	Tuberculosis	Yes [ ]	No [ ]
3.	Jaundice	Yes [ ]	No [ ]
4.	Chronic Cough	Yes [ ]	No [ ]
5.	Other (Specify)	_____	
6.	Hospitalization	Yes [ ]	No [ ]

Personal History (tick where appropriate)

Typhoid	Yes [ ]	No [ ]
Tuberculosis	Yes [ ]	No [ ]
Jaundice	Yes [ ]	No [ ]
Chronic Cough	Yes [ ]	No [ ]
Other (Specify)	_____	
Hospitalization	Yes [ ]	No [ ]
Allergies, Skin Disease, Ulcers	Yes [ ]	No [ ]
Asthmatic Attacks	Yes [ ]	No [ ]

If "Yes" to #6 above, then give details of date, place and reason: _____

_____

Declaration and Authorization of Applicant

I hereby declare that the information I have provided is true and completely correct. I authorize any physician, laboratory, clinic or hospital to release to the Public Health Department, Port-of-Spain Corporation (POSC) any information concerning my health or medical history. I also authorize the Public Health Department (POSC) to release information obtained for the purpose of this Food Handlers' Badge to the Ministry of Health in Trinidad and Tobago.

Applicant's Signature: _____ Date: _____

DO NOT WRITE BELOW THIS LINE

TO BE COMPLETED BY ATTENDING PHYSICIAN

Examination: Circle appropriate letter S - Satisfactory U - Unsatisfactory

Hair - S / U Eyes - S / U Nose - S / U Throat - S / U Skin - S / U

Hands - S / U Nails - S / U Feet - S / U Abdomen - S / U Limbs - S / U

Pulse - S / U Chest - S / U Heart - S / U General Appearances - S / U

Blood Pressure - S / U (State Reading) _____

Comments: _____

Referred: _____

Investigation: _____

Date Examined: _____ Recommended / Not Recommended

_____ _____

Official Stamp *Signature of Medical Officer*

_____ _____ _____

Address of Medical Officer *Phone Contact* *Name of Medical Officer (IN BLOCK LETTERS)*

THIS FORM IS NOT TO BE SOLD