



Medical Certificate

Course: _____

School Year: _____

PERSONAL INFORMATION

Name:			Age:
Date of birth:	Weight (kg.):	Height (cm.):	
Blood type:	Allergies (if any):	Medications (if any):	
Address:			Contact no.:
Temperature:	Pulse rate:	Respiratory rate:	Blood pressure:

THIS IS TO CERTIFY that _____, male/female,
_____ was physically examined by the undersigned and was diagnosed of:
course & year level

DIAGNOSIS:

REMARKS:

THIS CERTIFICATION IS ISSUED upon request of the above-name student/employee as requirement for:

- ☐ On-the-Job Training
☐ Return for work
☐ Travel
☐ Off-campus activity
☐ Others, please specify _____

Signature over Printed Name of Attending Physician
Date: _____

License Number

