



DC Office of the State Superintendent of Education

STAFF/VOLUNTEER HEALTH CERTIFICATE

Name: _____ Sex: Male Female

Child Development Facility Name: _____

Date of Birth: _____ Telephone No. _____
Area Code

Home Address: _____
Number Street Apt. (if applicable) City State Zip Code

I have examined the above-named person and certify that he/she:

- Is free from disease in communicable form
- Appears to be in satisfactory physical and mental health condition, capable of doing physical household tasks, supervise and give care to children.

In addition to a general physical health examination, the following tests have been done:

Tuberculin test (Check One): PPD Chest X-Ray

Date Result Signature of Recorder

Remarks: _____

MD/NP

Signature of Examining Physician/Nurse Practitioner

Date of Exam

Address

Area Code & Phone Number

PLEASE RETAIN A COPY FOR YOUR RECORDS