

**Legendary Therapy Plc
PHYSICAL EXAMINATION**

NAME: _____ Date of Birth: _____

GENERAL PHYSICAL FINDINGS:

Blood Pressure _____ Pulse _____ Respiration _____ Height _____ Weight _____
 Heart _____ Lungs _____ Musculo-Skeletal _____ GU _____
 GI _____

Test Required by Law of ALL Males & Females

SPECIFY

DISEASE IMMUNIZATION or TEST

	Test Date	Result	Result Date Date(s)	
PPD (Mantoux)	_____	_____	_____	
Tetanus (Every 10 years)	_____			
X-Ray if Positive PDD	_____	_____	_____	Mumps
<i>(see below if not conducted)</i>				

Please be advised that I have examined this patient on this day and have found him/her to be free of communicable diseases, particularly Tuberculosis. Review of signs and symptoms was completed and the patient is symptom-free. I do not recommend that the patient have a PPD or chest x-ray due to positive history of PPD. Dr.'s Initials _____

Rubella Vaccine _____
 Measles Vaccine 1 _____ 2 _____
 HB Vaccine 1 _____ 2 _____
 Diptheria _____

Rubella Titre _____
 Immunizations missing/refused: _____
 Rubella Titre (if born _____
 before 1/1/57 rubella verified) _____

(Read and Sign under attestation below)

Specify any follow-up treatment needed or delay due to pregnancy:

MEDICATIONS (List all medications prescribed on a continuing basis):

Physical Limitations (to the best of your knowledge):

a. Does this person require eyeglasses? No Yes Hearing Aid? No Yes

b. Has this person been treated for any disease entity or injury which hampered his/her ability to function normally for extended periods. No Yes If yes, explain:

c. Is this person presently being treated for any disorders of a chronic or recurring nature? (Please include any history of back injury, congenital defect, brain or nervous disorders, etc): No Yes If yes, explain:

The above named is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation of addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior. This person both mentally and physically capable of performing the duties of a therapist in the home and community environment of infants, toddlers, and preschoolers.

Date: _____ Physician Name: _____
License#: _____

Please Print

Signature

Address: _____ Phone: () _____

THIS FORM MUST BE COMPLETED AND RETURNED TO THIS OFFICE PRIOR TO ANY CASE ASSIGNMENT!