



Doctor's Medical Certificate

To be completed by your Doctor

Personal Details

Surname: _____ Female Male
 First name: _____
 Date of birth: ___ - ___ - _____ / Height: ___ metres / Weight: ___ kilos
 Address: _____
 Tel: _____
 Fax: _____

1. Does the applicant presently suffer from or has ever had the following?

	Yes	No		Yes	No		Yes	No
Allergies:	<input type="checkbox"/>	<input type="checkbox"/>	Anaemia:	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia:	<input type="checkbox"/>	<input type="checkbox"/>
Apendicitis:	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis:	<input type="checkbox"/>	<input type="checkbox"/>	Asthma:	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia:	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox:	<input type="checkbox"/>	<input type="checkbox"/>	Depression:	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Fainting:	<input type="checkbox"/>	<input type="checkbox"/>	Eye problems:	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions:	<input type="checkbox"/>	<input type="checkbox"/>	German Measles (Rubella):	<input type="checkbox"/>	<input type="checkbox"/>	Glandular Fever:	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis:	<input type="checkbox"/>	<input type="checkbox"/>	Hernia:	<input type="checkbox"/>	<input type="checkbox"/>
Herpes (cold sores):	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Malaria:	<input type="checkbox"/>	<input type="checkbox"/>
Measles:	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems:	<input type="checkbox"/>	<input type="checkbox"/>	Miscarriage:	<input type="checkbox"/>	<input type="checkbox"/>
Migraine/Headaches:	<input type="checkbox"/>	<input type="checkbox"/>	Mumps:	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Illness:	<input type="checkbox"/>	<input type="checkbox"/>
Polio:	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever:	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis:	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers:	<input type="checkbox"/>	<input type="checkbox"/>

If answered Yes to any of the above, please give details and dates as applicable:

2. Please indicate if the applicant has been immunised against the following:

	Yes	No	Date		Yes	No	Date
Tetanus:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Mumps:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Typhoid:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Measles:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Diphtheria:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Whooping Cough:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Tuberculin Test:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	German Measles (Rubella):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Polio:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>				

3. Is the applicant currently, to the best of your knowledge, a likely carrier for any infectious disease, such as Hepatitis B or HIV virus?

Yes No

If answered Yes to any of the above, please give details:

Name of doctor: _____

Address: _____

Tel: _____

Fax: _____

Doctor's stamp or seal of the practice:

Signature:

Date: ____ - ____ - _____