



HEALTHCARE NETWORK

20042 19th Avenue NE, Shoreline, WA 98155

Subject: Statement of Health and Immunization

Date: Revised on 1/28/08

Please indicate if you had; do you presently have; or are you under a physician's care for the following by placing a check (v) in the appropriate category.

Statement of Health

	Yes	No		Yes	No
Allergies	_____	_____	Tuberculosis	_____	_____
Asthma	_____	_____	High Blood Pressure	_____	_____
Back Pain	_____	_____	Surgery	_____	_____
Chest Pain	_____	_____	Other Illness (es)	_____	_____
Headaches	_____	_____	Injuries Treated by	_____	_____
Hearing Loss	_____	_____	a Doctor		

If you answered **YES** to any of the above questions, please specify dates of occurrence and if any complications resulted from the described illness or injury.

Statement of Immunization

_____ I have received the complete Hepatitis B Vaccine series Year: _____

_____ I have not received the complete Hepatitis B Vaccine series.

_____ I have received the complete Mumps, Measles and Rubella Series. Year: _____

_____ I have not received the complete Mumps, Measles and Rubella Series.

I hereby certify that the above information is **true and correct** to the best of my knowledge.

Name

Signature

Date

Witness's Name

Witness's Signature

Date