UPPER BUCKS COUNTY TECHNICAL SCHOOL
HEALTH CARE CAREERS
HEALTH FORM

Student Name: _____

Address: _____

Phone Number: _____Date of Birth: _____

Physician Statement

☐ The above-named individual was examined and has been determined to be free of communicable disease and is in a non-communicable state.

☐ The above-named individual has full use of his/her hands, the ability to stand for extensive periods of time, and the ability to perform bending, pushing, pulling, and lifting a minimum of 40 pounds without restrictions.

SIGNATURE: _____
(Examining physician, physician's assistant, or nurse practitioner)

PRINTED NAME: _____

ADDRESS: _____

PHONE NUMBER: _____DATE: _____