PHYSICIAN'S CERTIFICATE FOR MINOR WORK PERMIT

APPLICANT INFORMATION

Name of Student / Applicant in full: ________________________

Sex: [ ] Male [ ] Female

Date of Birth: ________________________ Height: ______ ft. ______ in.

Weight: ______ lbs. Color of Hair: ________________________ Color of Eyes: ________________________

Distinguishing Characteristics, if any: ________________________

School District: ________________________ Building: ________________________

Parent or Guardian: ________________________ Parent or Guardian Telephone Number: ________________________

PHYSICIAN'S APPROVAL

THE UNDERSIGNED HEREBY CERTIFIES THAT THEY HAVE THOROUGHLY EXAMINED THE ABOVE NAMED APPLICANT WHO WAS BORN ON THE DATE STATED ABOVE, AND WHO MEETS THE DESCRIPTION GIVEN HEREON, AND THAT SAID PERSON;

[ ] IS [ ] IS NOT

IN THEIR OPINION PHYSICALLY FIT TO PERFORM THE WORK OF ANY EMPLOYMENT NOT FORBIDDEN BY LAW TO A PERSON OF THIS AGE AND SEX.

X ________________________

Physician's Signature

Date Signed: ________________________

NOTE: IF WORK SHOULD BE LIMITED TO A CERTAIN TYPE OF EMPLOYMENT, THE PHYSICIAN MUST MARK THIS FORM ACCORDINGLY IN THE AREA BELOW.

Limited Certificate: [ ] YES [ ] NO

If Marked YES; Employment should be Limited to Work Specified Below.

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