**ActionStaff.com**
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# Physical Form

**Patient Information**

_____ _____ _____
**Patient's Name** **Date of Birth** **Today's Date**

_____ _____ _____ _____ _____
**Height** **Weight** **Blood Pressure** **Pulse** **Respirations**

_____ **Does the patient have a latex allergy? _____ Yes _____ No**
**List of Patient's Allergies**

**Restrictions/Limitations**

_____
_____
_____
_____
_____

**Physician's Statement**

**I have examined the individual named above, and to the best of my knowledge, he/she is in good physical and mental health, free of any communicable diseases, and able to function his/her profession at full capacity without limitations or restrictions. By signing below I certify that the above information is valid and if accommodations or restrictions are required, they will be documented above.**

_____ _____ _____
**Physician's Signature** **Physician's Name** **Date**