

**Physician's Statement
Provided for Substitutes**

WEST BRANCH COMMUNITY SCHOOLS

P.O. Box 637

West Branch, Iowa 52358

Name _____ Date _____

Eyes: Is vision adequate in right? _____ left? _____
If corrected, is corrected vision adequate? _____

Ears: Right _____ Left _____ Is the hearing normal? _____

Temperature _____ Pulse _____ Blood Pressure _____

Urinalysis: Results _____

Heart: Are there any signs of symptoms or disease of the heart? _____

Are there any signs or symptoms of disease of the lungs, mouth or mucus membranes?

General Condition: _____Excellent _____Good _____Fair _____Below Average

This is to certify that I have examined the above named and find him/her to be free of all communicable diseases, and do consider him/her physically capable to work in the West Branch Community Schools.

Physician's Signature

Physician's Printed/Typed Name

Address _____
