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.

☐ YES  ☐ NO

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

Limited Certificate:

Employment should be Limited to Work Specified Below:

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.

LAWS COM 0000 (Replaces OHIO FORM V)