Creative Therapies of WNY

Phone: 716.472.1289
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ANNUAL HEALTH STATEMENT

NAME: _____

ADDRESS: _____
_____

Date of Birth: _____

Annual Mantoux/PPD or chest X-ray: Date _____

Results_____

The above person has received the following recommended vaccines or has documented refusal:

Received	Refused	
_____	_____	Hepatitis B vaccine
_____	_____	Tetanus immunization w/in the past 10 years
_____	_____	Diphtheria
_____	_____	Pertussis
_____	_____	Varicella
_____	_____	Influenza

YES or NO Does the person listed above have a diagnosed disorder that would preclude him/her from providing Speech, OT, PT or Special Instruction services?

YES or NO Does the person listed above have a communicable disease?

Examining Physician Signature _____
Date _____

Print Physician's Name & Address:
_____
_____
_____