



## Verification of Physical Exam

I hereby acknowledge that the undersigned patient has had a physical wellness exam. This certifies that I have advised and encouraged the patient to follow up with of all recommended tests and procedures, but the patient is not obligated to follow these recommendations for the purpose of this document.

Health Care Provider Name (printed)

Health Care Provider Signature

\_\_\_\_\_

\_\_\_\_\_

License No. \_\_\_\_\_

Phone Number \_\_\_\_\_

Date \_\_\_\_\_

Employee or dependent: Upon obtaining your health care provider's signature, please sign and return this form to the district office.

Name (printed)

Signature

\_\_\_\_\_

\_\_\_\_\_

I am an employee.

I am a spouse.

I am a dependent.

*Mission: Educate students to be lifelong learners who are productive, responsible citizens.*

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