MEDICAL FORM FOR TESTING FOOD HANDLERS

NAME:…………………………….. AGE:……………………………………SEX:…………………………………..

ADDRESS OF EMPLOYEE……………………………………………………………………………………………………..

STOOL MICROSCOPY/CULTURE………………………………………………………………………………

WIDAL………

NASAL SWAB……………………………………………………………………………………………………

RPR/VDRL……………………………………………………………………………………………………….

CHEST X-RAY…………………………………………………………………………………………………

NAME OF DOCTOR…………………………………………………………………………….

DOCTORS SIGNATURE………………………………………………………………………..

DATE …………………………………………………………………………………………

IN CARE OF…….