



Medical Form

INSTRUCTIONS TO THE PARENT OR GUARDIAN:

Do not complete this form until after the applicant is interviewed by PAYH personnel. When the appropriate medical officials complete the remainder in its entirety, mail to address below.

PART I

PERSONAL REPORT

DATE: _____

Name: _____ Birthday: _____ / _____ / _____

Address: _____ Soc. Sec. #: _____ - _____ - _____

_____ Tel: () _____

e-mail: _____ Fax: () _____

If any family member has experienced any of the following, please mark with an (X) and explain:

CONDITION	FAMILY MEMBER(S) AFFECTED
_____ Alcoholism	_____
_____ Allergy	_____
_____ Asthma	_____
_____ Cancer	_____
_____ Diabetes	_____
_____ Drug Addiction	_____
_____ Epilepsy	_____
_____ Heart Disease	_____
_____ Hemorrhagic Disease	_____
_____ Kidney Disease	_____
_____ Mental Illness	_____
_____ Tuberculosis	_____

Is applicant adopted? _____ YES _____ NO

Please check and give age at which applicant has been treated for any of the following:

DISEASE	CHECK	AGE	DISEASE	CHECK	AGE
Allergies	_____	_____	Kidney Disease	_____	_____
Asthma	_____	_____	Mastoiditis	_____	_____
Backaches	_____	_____	Measles	_____	_____
Bed Wetting	_____	_____	Meningitis	_____	_____
Bronchitis	_____	_____	Mononucleosis	_____	_____
Chicken Pox	_____	_____	Mumps	_____	_____
Colds	_____	_____	Nervousness	_____	_____
Constipation	_____	_____	Nose Bleeds	_____	_____
Convulsions	_____	_____	Otitis Media	_____	_____
Coughs	_____	_____	Pleurisy	_____	_____
Diarrhea	_____	_____	Pneumonia	_____	_____
Diphtheria	_____	_____	Poor Appetite	_____	_____
Fainting Spells	_____	_____	Rheumatic Fever	_____	_____
German Measles	_____	_____	Rheumatism	_____	_____
Hay Fever	_____	_____	Scarlet Fever	_____	_____
Headaches	_____	_____	Sinus Trouble	_____	_____
Hearing Problems	_____	_____	Skin Disorders	_____	_____
Heart Disease	_____	_____	Sore Throats	_____	_____
Indigestion	_____	_____	Strep Throat	_____	_____
Influenza	_____	_____	Tonsillitis	_____	_____
Insomnia	_____	_____	Typhoid	_____	_____
Joint Pains	_____	_____	Whooping Cough	_____	_____

If others, please list below:

Please list the following:

SURGERIES	DATE	ACCIDENTS or BROKEN BONES	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has this applicant ever had an ALLERGIC REACTION to medicines, food, or insect bites? _____ YES _____ NO
 If YES, Please discuss: _____

Has applicant ever had to discontinue study because of physical or emotional disturbances? _____ YES _____ NO
 If YES, Please discuss and include dates: _____

Has he ever had any limitation placed on the amount and type of physical exercise? _____ YES _____ NO
 If YES, Please discuss and include dates: _____

Has he ever required the services of a psychiatrist or a consulting psychologist for the treatment of any emotional or mental disorders? _____ YES _____ NO

If YES, please indicate full names and addresses of psychiatrists or psychologists who have treated him giving dates:

NAME	ADDRESS	TELEPHONE	DATE
		()	
		()	
		()	

List any conditions which would limit this applicant's participation in physical education or work. _____

Has he ever been diagnosed or treated by a member of the medical profession as having a deficiency of the immune system such as Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? _____ YES _____ NO

Has he experienced any other disturbances of health? _____ YES _____ NO
 If YES, please discuss: _____

Do you have HEALTH INSURANCE on this applicant? _____ YES _____ NO
 If YES, in whose name is the policy listed? _____

Do you have DENTAL INSURANCE on this applicant? _____ YES _____ NO
 If YES, in whose name is the policy listed? _____

Do you have ORTHODONTIC INSURANCE on this applicant? _____ YES _____ NO
 If YES, in whose name is the policy listed? _____

*****Please provide copies of all insurance/prescription cards and attach to this medical form.**

PART II
MEDICAL EXAMINATION

DATE: _____

TO THE EXAMINING PHYSICIAN: A complete physical examination is required.

NAME: _____

AGE: _____

PAST HISTORY

Serious Illness and Dates: _____

Injuries and Dates: _____

Surgeries and Dates: _____

Drug Reactions and Dates: _____

HEIGHT	WEIGHT	HEART RATE	BLOOD PRESSURE

CHECK EACH ITEM IN APPROPRIATE COLUMN:

	NORMAL	ABNORMAL	COMMENTS
Skin			
Head, Scalp			
Eyes, Pupils			
Fundoscopy			
Ears			
Nose & Sinuses			
Mouth & Teeth			
Pharynx & Tonsils			
Lymphadenopathy			
Breasts			
Lungs			
Neck, Trachea, & Thyroid			
Heart			
Abdomen			
Genitalia			
Spine & Musculoskeletal			
Extremities			
Reflexes			

IMMUNIZATION RECORD

<u>NAME OF IMMUNIZATION</u>	<u>DATES GIVEN</u>
DPT (Diphtheria, Pertussis, Tetanus)	_____
Hepatitis B Vaccine	_____
Hepatitis B Titer	_____
HIB Vaccine	_____
MMR (Measles, Mumps, Rubella)	_____
Poliomyelitis Vaccine	_____
Tetanus Toxoid	_____
Other: _____	_____

Note: If record is available, please attach.

REQUIRED LABORATORY STUDIES

1. CBC _____
 RPR _____
 HTLV III _____
 Blood Sugar _____
 Hepatitis Screening _____
2. Urinalysis:
 Specific Gravity _____ Alb _____ Sugar _____
 Microscopic _____
3. Tuberculin Test _____ Date: _____
 (If results doubtful or positive, perform chest x-ray)
4. Other labs indicated secondary to history or physical findings: _____

Do you consider this applicant physically fit to undertake the Paul Anderson Youth Home's activities?

_____ YES _____ NO If NO, please explain: _____

Was applicant's behavior appropriate during exam? _____ YES _____ NO

If NO, please explain: _____

Is this applicant taking any prescribed medication? _____ YES _____ NO If YES, please give the following:

NAME	STRENGTH	DOSAGE	DATE BEGUN	DATE TO END

Based on the examination and the information made available to me, I hereby certify that the applicant is free from any infectious disease, is in good general health, and is physically able to participate in the activities of the Paul Anderson Youth Home.

Physician's Name: _____ (please type or print)

Signature: _____, M.D. Date: _____

Address: _____

Tel: () _____ Fax: () _____

EYE INFORMATION

Vision: R _____ / _____ L _____ / _____
Glasses: R _____ / _____ L _____ / _____
Contacts: R _____ / _____ L _____ / _____
Comments: _____

Physician's Name: _____ (please type or print)
Signature: _____ Date: _____
Address: _____
Tel: () _____ Fax: () _____

HEARING INFORMATION

R _____ L _____
Comments: _____

Physician's Name: _____ (please type or print)
Signature: _____ Date: _____
Address: _____
Tel: () _____ Fax: () _____

DENTAL INFORMATION

Date of last cleaning: _____
Condition of teeth: _____ Excellent _____ Good _____ Fair _____ Poor
Comments: _____

Dentist's Name: _____ (please type or print)
Signature: _____ Date: _____
Address: _____
Tel: () _____ Fax: () _____

ORTHODONTIC INFORMATION

If the applicant wears braces, please complete the following: Date of last orthodontic appointment: _____
Date when next orthodontic appointment should be scheduled: _____
Comments: _____

Orthodontist's Name: _____ (please type or print)
Signature: _____ Date: _____
Address: _____
Tel: () _____ Fax: () _____