



INDUCTION APPLICANT'S PHYSICAL EXAMINATION

TO BE COMPLETED BY APPLICANT

Name _____ D.O.B. _____

Allergies : _____

Medication currently prescribed & reason for use: _____

History of chronic or major illness _____

Surgeries: _____

Immunizations:

When was your last Tetanus immunization? _____

Did you have these childhood immunizations: Rubella Polio Mumps Measles Other _____

Health History:

NO	YES		NO	YES	
<input type="checkbox"/>	<input type="checkbox"/>	Head, Spinal or Other Serious Injury	<input type="checkbox"/>	<input type="checkbox"/>	Seizures, Fit, Convulsions or Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Extensive Confinement by Illness/Injury	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular Disease
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis or Gonorrhea or Other V.D.
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Cancer or Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Nervous Stomach	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Any Other Nervous Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Suffering From Any Other Disease
<input type="checkbox"/>	<input type="checkbox"/>	Permanent Defect From Illness, Disease or Injury			

COMMENTS:

CONFIDENTIAL RELEASE

I hereby grant a full release of this medical information (both sides of this form) to TEEN CHALLENGE of SOUTHERN CALIFORNIA (TCSC) and its agents. I further grant TCSC or its agents the right to have conferences, including telephone conferences, with your agency or affiliates for purposes of discussing said information for purposes of effecting satisfaction of the needs and purposes of TCSC.

Signature

Date

PHYSICAL EXAMINATION CODE

SatisfactoryS
 Not Satisfactory.....NS
 Not Examined.....NE

*Physician's Assistant, Nurse Practitioner or Medical Doctor must complete everything on this page and print name, date, phone number and sign at the bottom. **Must Be Legible.***

VITAL DATA: Height: __ Ft. __ In. Weight: _lbs. Blood Pressure _____mmHG
 Pulse _____/min Temperature _____

GENERAL APPEARANCE & DEVELOPMENT (including signs of drug abuse) Good Fair Poor
 PHYSICAL EXAMINATION:

System	Negative Findings	Positive Findings/Comments
Skin		
Head		
Eyes		
Ears-Nose- Throat		
Neck		
Thorax-Breast		
Heart		
Lungs		
Abdomen		
Back-spine		
Extremities		
Reflexes		

V.D.R.L. _____ Urinalysis _____ HIV _____

TB Skin Test _____ If positive, check X-Ray results _____

Hepatitis A, B & C _____ Pregnancy Test (by urinalysis) _____

GENERAL COMMENTS AND RECOMMENDATIONS ON ABOVE: _____

Signature of Examining Medical Personnel: _____

Address _____ City, State, ZIP _____

Phone Number _____

Date Examined _____

PLEASE STAMP THIS FORM WITH YOUR OFFICE STAMP