



# Medical Examination Report

## To the Parent or Guardian:

Complete this top section. The remainder of this form is to be completed by the student's physician.

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_  
 Last First Middle  
 Address \_\_\_\_\_ Parent's Name \_\_\_\_\_  
 City \_\_\_\_\_ Prov/State \_\_\_\_\_ Postal Code/Zip \_\_\_\_\_ Country \_\_\_\_\_

## To the Physician:

In order that the student's program can be adjusted to his physical condition, and in order that sound health counseling can be given to him/her, it is necessary for **Heritage Academy** to have a report of the student's physical condition. This report will be held in confidence and used only for the protection and aid of the student in his education. Please record on this form the positive findings of your examination, and your recommendations to the school.

## Health Inventory:

Is the student subject to the following?

Headaches _____	Insomnia _____	Frequent Colds _____	Allergies _____
Sinusitis _____	Cough _____	Indigestion _____	Constipation _____
Anxiety _____	Depression _____	Attention Deficit _____	Fainting _____

For female students, please discuss menstrual history.

Age at onset \_\_\_\_\_ Interval \_\_\_\_\_ Duration \_\_\_\_\_ Pain \_\_\_\_\_

Does this student have to stay in bed for a day or more? \_\_\_\_\_

Is this student accustomed to taking medication during menses? \_\_\_\_\_

If so, what are the medications? \_\_\_\_\_

## Physical Findings:

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

### Eye Examination

Right Eye _____	Left Eye _____	Right Eye _____	Left Eye _____
uncorrected	uncorrected	corrected	corrected

### Ear Examination

Right Ear \_\_\_\_\_ Left Ear \_\_\_\_\_

General Physique _____	Fair _____	Robust _____	Skin _____	Nose _____
Mouth _____	Circle one _____	Teeth _____	Gums _____	Tonsils _____
Lymphadenopathy _____	Neck _____	Trachea _____	Heart _____	Thyroid _____
Chest _____	Lungs _____	Genitalia _____	Abdomen _____	Pelvic, Vaginal _____
Gastrointestinal _____	Hernia _____	Spine _____	Neurological _____	Reflexes _____
Anus, Rectum _____	Muscular-skeletal _____	Feet _____	Alertness _____	
Psychiatric _____	Upper Extremities _____	Metabolic _____		
Scars _____	Body Marks _____			



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## Laboratory Findings:

Urinalysis \_\_\_\_\_ Hgb/Hct \_\_\_\_\_ Blood Sugar \_\_\_\_\_ Tonsils \_\_\_\_\_

### Tuberculosis Clearance

*If skin test is positive, an X-ray is required*

Skin Test Date \_\_\_\_\_ Results \_\_\_\_\_

Chest X-ray Date \_\_\_\_\_ Results \_\_\_\_\_  
*If chest X-ray is positive, what treatment was given?*

1. Is there any physical reason why this applicant should not participate in vocational or recreational activities? ☐ Yes ☐ No  
If so, please give reasons \_\_\_\_\_
2. Does this student have any allergies to food or medicine? ☐ Yes ☐ No  
If so, please list all allergies \_\_\_\_\_
3. Is there any reason to suspect that this student has been involved with drug or alcohol abuse? ☐ Yes ☐ No  
If so, please describe \_\_\_\_\_
4. Is there any reason to suspect that this student has been exposed to A.I.D.S.? ☐ Yes ☐ No  
If so, please describe \_\_\_\_\_
5. Does the student appear to be emotionally stable? ☐ Yes ☐ No  
If not, please describe \_\_\_\_\_

## Questions:

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Prov/State \_\_\_\_\_ Postal Code/Zip \_\_\_\_\_ Country \_\_\_\_\_

I hereby certify that the above named applicant is free from any infectious disease, is in good general health, and is able to live and participate in vocational activities in a Christian boarding academy.

Signature of Physician: \_\_\_\_\_ Date \_\_\_\_\_

