ASi
Youth for Jesus

Medical Examination Report

To the Parent or Guardian:

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

Participant's Name _____ **Date of Birth** _____
Last First Middle

Address _____ **Parent's Name** _____

City _____ **Prov/State** _____ **Postal Code/Zip** _____ **Country** _____

To the Physician:

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

Health Inventory:

Is the participant subject to the following?

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

For female participants, please discuss menstrual history.
Age at onset _____ Interval _____ Duration _____ Pain _____
Does this participant have to stay in bed for a day or more? _____
Is this participant accustomed to taking medication during menses? _____
If so, what are the medications? _____

Physical Findings:

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Eye Examination
Right Eye _____ (uncorrected) Left Eye _____ (uncorrected) Right Eye _____ (corrected) Left Eye _____ (corrected)

Ear Examination
Right Ear _____ Left Ear _____

General Physique Poor Fair Good Robust (Circle one) Skin _____ Nose _____

Mouth		Teeth		Gums		Tonsils	
Lymphadenopathy		Neck		Trachea		Thyroid	
Chest		Lungs		Heart		Abdomen	
Gastrointestinal		Hernia		Genitalia		Pelvic, Vaginal	
Anus, Rectum		Muscular-skeletal		Spine		Neurological	
Psychiatric		Upper Extremities		Feet		Reflexes	
Scars		Body Marks		Metabolic		Alertness	

ASI Youth for Jesus

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Laboratory Findings:

Urinalysis _____ Hgb/Hct _____ Blood Sugar _____ Tonsils _____

Tuberculosis Clearance Skin Test Date _____ Results _____
If skin test is positive, an X-ray is required

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

Circle one

1. Is there any physical reason why this applicant should not participate in recreational activities? Yes No
   If so, please give reasons _____
   _____

2. Does this participant have any allergies to food or medicine? Yes No
   If so, please list all allergies _____
   _____

3. Is there any reason to suspect that this participant has been involved with drug or alcohol abuse? Yes No
   If so, please describe _____
   _____

4. Is there any reason to suspect that this participant has been exposed to A.I.D.S.? Yes No
   If so, please describe _____
   _____

5. Does the participant 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 activities in a Christian boarding environment.

Signature of Physician: _____ **Date** _____