Physician's Form
(Must be completed by a licensed physician)

Applicant's Name ____

Medical Diagnosis ____

Height __________ Weight __________ Pulse ______________ Blood Pressure ______________

Urinalysis Done? _______________ Hgb. Done? _______________ Tine Test _________________

Eyes ___________________________________

Glasses _________________________________

Contacts ________________________________

Ears ____________________________________

Nose ____________________________________

Mouth ___________________________________

Throat ___________________________________

Teeth ___________________________________

Heart ____________________________________

Lungs ____________________________________

Lymph Nodes ______________________________

Abdomen _________________________________

Genitalia _________________________________

Hernia ___________________________________

Extremities _______________________________

Posture (Spine) ____________________________

Skin ______________________________________

Allergy (Please specify) _____________________

____

Menstrual History __________________________

General Appraisal __________________________

____

Immunization Record (Write in date of applicant's last booster)

DTaP _________________ Td Booster ________________ Hep B __________________

Hib ___________________ Polio _____________________ Varicella ________________

MMR __________________ Measles Dose 2 _____________ Other ___________________

Swimming

Is applicant permitted to swim in a lake? ____

List any swimming restrictions ____

(Continued on the other side)

Diet and Environment

Applicant's food allergies ____

Applicant's special diet ____

____

Additional comments, restrictions or recommendations _______________________________________

____

Please include with this form a list of all current medications.

Physician's Name ____

Office Address ____

____

Office Phone Number ____

Physician's Signature ____ Date ______________