Wisconsin Teen Challenge

Medical History
and
Physical Examination Form

Name: _____ Induction Center: _____

Birthdate: _____ Social Security # _____

1. The following lab work is **REQUIRED** for admission the program and copies included at the time of entrance:

   A. RPR- Reactive or Non-reactive (*circle one*) _____ (*date read*)

   B. HIV Screening – Pos. or Neg. _____ (date read)

   C. Pregnancy Test – Pos. or Neg. (for potential female students only)

   D. Liver function tests - _____ (*date read*)

   E. Hepatitis Screening, if indicated, based on history or abnormal liver function test results

      Circle pos. or neg. for each: **Hepatitis A** - Pos. or Neg.; **Hepatitis B** – Pos. or Neg.; **Hepatitis C** – Pos or Neg.

2. TB testing is **MANDATORY** and results included should be no older than 6 months prior to admission to the Induction Center. Tetanus shot must be up-to-date with documentation or date given.

Tuberculin Test / PPD	Date:_____ Size:_____ Chest x-ray _____
Tetanus toxoid	Date _____

3. Immunizations should be up-to-date and include:
   Measles _____ (date performed) Mumps _____ (date performed) Rubella _____ (date performed)

4. Significant Medical Conditions:

	Yes	No	If Yes, please explain.
ASTHMA			
CARDIAC			
CHEMICAL DEPENDANCY			
DRUGS			
ALCOHOL			
DIABETES MELLITUS			
GASTROINTENTESTINAL DISORDER			
HEARING DISORDER			
HYPERTENTION			
NEUROMUSCULAR DISORDER			
ORTHYOPEDIC CONDITION			
RESPIRATORY ILLINESS			
SEIZURE DISORDER			
SKIN DISORDER			
VISION DISORDER			
OTHER (SPECIFY)			

5. Current / routine medications:

MEDICATION	DOSAGE
1.	
2.	
3.	
4.	

6. Please list any allergies you have to any medications, foods, or other substances. _____

_____

_____

7.

Report of Physical Examination	Normal	Abnormal	If Abnormal, please explain.
HEIGHT (INCHES)			
WEIGHT (POUNDS)			
TEMPERATURE			
PULSE ( )			
BLOOD PRESSURE			
HAIR / SCALP			
SKIN			
EYES - VISUAL ACUITY (R__/__ L__/__)			
EYES – COLOR VISION			
EARS HEARING (dB R L)			
NOSE AND THROAT			
TEETH AND GINGIVA			
LYMPH GLANDS			
HEART – MURMUR, ETC.			
LUNG – ADVENTIOUS FINDINGS			
ABDOMEN			
GENITALIA			
NEUROMUSCULAR SYSTEM			
EXTREMITIES			
SPINE (PRESENCE OF SCOLIOSIS)			

8. Physician's observations and comments (be specific): _____

_____

_____

_____

_____

Name of Examiner (please print) Address

Signature of Physician Date of Examination