Great Lakes Adult and 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. *COVID-19 test is MANDATORY. Students must present negative COVID-19 test results not longer than 24 hours prior to arrival.

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			

5. Current / routine medications:

MEDICATION	DOSAGE
1.	
2.	
3.	
4.	

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

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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): ____________________

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9. General Appearance: ______________________________

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Name of Examiner (please print)   Address

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Signature of Physician   Date of Examination