Great Lakes Adult and Teen Challenge
Medical History and
Physical Examination Form

Name: _____ Birthdate: ___/___/_____

1. **Lab Work** The following is REQUIRED for admission the program. Please include copies at the time of induction:
   A. RPR: Reactive or Non-reactive *(circle one)* Date Read: ___/___/_____
   B. HIV Screening: Positive or Negative *(circle one)* Date Read: ___/___/_____
   C. Pregnancy (female students only): Positive or Negative *(circle one)*
   D. Liver function tests: Normal or Abnormal *(circle one)* Date Read: ___/___/_____
   E. Hepatitis Screening, if indicated, based on history or abnormal liver function test results. Circle for each: **Hepatitis A:** Positive or Negative **Hepatitis B:** Positive or Negative **Hepatitis C:** Positive or Negative
2. **COVID-19 Test** Positive or Negative *(circle one)* Date Tested: ___/___/_____
   Students must present negative COVID-19 test results not longer than 24 hours prior to arrival.
3. **TB Test** This is MANDATORY and results included should be no older than 6 months prior to admission to Adult and Teen Challenge. Tetanus shot must be up-to-date with documentation or date given.

Tuberculin Test / PPD	Date: Size: Chest X-Ray
Tetanus toxoid	Date:

4. **Immunizations** should be up-to-date, please list date performed:
   Measles: ___/___/_____ Mumps: ___/___/_____Rubella: ___/___/_____

5. **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			

6. **Current / Routine medications**

MEDICATION	DOSAGE
1.	
2.	
3.	
4.	

7. **Allergies** Please list any allergies you have to any medications, foods, or other substances.

_____

_____

_____

8. **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)			

9. **Physician's observations and comments**

_____

_____

_____

10. **General Appearance**

_____

_____

_____

_____ _____

Name of Examiner (print) Address

_____ _____

Signature of Physician Date of Examination