

This confidential information should be made available only to the medical coordinator and physician.

Height _____ Weight _____ Pulse _____ B/P _____

List Allergies: _____ Hemophilia: _____ Other: _____

	NORMAL	IF ABNORMAL, DESCRIBE HERE	NORMAL	YES	FOLLOW-UP NO
Ears (hearing, absence or cerumen)					
Eyes (reflexes, movements, visual acuity)					
Nose, Throat, Sinuses					
Gums					
Teeth					
Neck					
Lungs					
Breasts					
Lymph Nodes					
Heart					
Absence of Hernia					
Back					
Skin					
Bones, Joints, Muscles					
Nervous System					

OPTIONAL

Chest X-Ray _____		
Sickle Cell Prep _____	Urine Albumin _____	Blood _____
Sugar _____	Wgt. _____	
Immunization Record: Tetanus _____		Booster _____
Needed Yes _____ No _____	Date _____	
Diphtheria _____		Booster _____
Needed Yes _____ No _____	Date _____	
Polio _____		Booster _____
Needed Yes _____ No _____	Date _____	
Medical History (including current medications taken): _____		

General physical condition _____

May participate in program Yes _____ No _____

Additional comments or recommendations _____

