PHYSICAL EXAMINATION CERTIFICATE

Must be completed and signed by Physician and Parent/Guardian.

FOR DEPARTMENT USE ONLY

Last Name _____

First Name:_____ Boys State #_____ City _____ County_____

APPLICANT – COMPLETE NAME AND MAILING ADDRESS

NAME:_____ ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

ATTENTION PHYSICIAN: Boys' State, by nature, is strenuous – both physically and emotionally. Therefore, ability to cope adequately with these conditions should be seriously considered when completing this form.

PERSONAL HISTORY: Has the participant ever had any of the following:

___ Chicken Pox	___ Measles	___ Mumps
___ Scarlet Fever	___ Frequent Colds	___ Frequent Sore Throats
___ Ear Infection	___ Sinusitis	___ Tonsillitis
___ Bronchitis	___ Pneumonia	___ Congenital Heart Problem
___ Rheumatic Fever	___ Rheumatoid Arthritis	___ Epilepsy
___ Psychiatric Disorder	___ Emotional Disorder	___ Tuberculosis
___ Diabetes	___ Anemia	___ Orthopedic Problems
___ Infectious Jaundice/Hepatitis	___ Kidney Disease	___ Mononucleosis
___ Chronic Intestinal Problems	___ Malignancy	___ Asthma
___ Hay Fever	___ Hives	___ Operations

PHYSICAL EXAMINATION

Height: _____ Weight:_____ Blood Pressure:_____ Pulse:_____ Hearing:_____

Visual Acuity: _____ R_____ L_____

CLINICAL EXAMINATION

(Check each item in proper column. Enter NE if not evaluated.)

	NORMAL	ABNORMAL	COMMENTS
1. Eyes	_____	_____	_____
2. Ears, Nose, Throat	_____	_____	_____
3. Hearing	_____	_____	_____
4. Mouth/Teeth	_____	_____	_____
5. Cardiovascular	_____	_____	_____
6. Chest/Lungs	_____	_____	_____
7. Abdomen	_____	_____	_____
8. Genitourinary	_____	_____	_____

(over)

	NORMAL	ABNORMAL	COMMENTS
9. Musculoskeletal	_____	_____	_____
10. Metabolic	_____	_____	_____
11. Neurological	_____	_____	_____
12. Skin	_____	_____	_____
13. Lymphatic	_____	_____	_____
14. Psychiatric	_____	_____	_____

Injuries:_____

Allergies (Food/Drugs):_____

Dates of: DPT or DT Booster_____ MMR: _____

Does this boy have any physical limitations or restrictions which would hinder his participation in Boys' State?

Yes____ No ____ (If yes, please explain.)

_____

_____

Physician's Signature: _____ Date: _____

Address:_____

Phone: _____

TO BE COMPLETED BY PARENT/GUARDIAN

Person to notify in case of an emergency:

NAME:_____ PHONE: _____

ADDRESS: _____

NOTE TO PARENT OR GUARDIAN: In order to quickly procure any emergency care that may be necessary for the candidate and to protect the physicians and institutions involved, please complete and sign below:

I, the parent/guardian of _____, do hereby authorize the nursing and
(NAME OF STUDENT)
medical staff of Morrisville State College's Student Health Center to treat my son for illness or injury as appropriate. I also give permission to local emergency room departments and their physicians, to provide appropriate medical, psychiatric, and surgical treatment, including administering anesthetics, as medically indicated in case of emergency.

_____ _____Parent _____ Guardian (check one)
Parent/Guardian Signature