

# 2018 PHYSICAL EXAMINATION CERTIFICATE

## FOR DEPARTMENT USE ONLY

Last Name \_\_\_\_\_  
First Name: \_\_\_\_\_ Boys State # \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_

### APPLICANT NAME AND MAILING ADDRESS

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**PERSONAL HISTORY:** Indicate if the participant has ever had any of the following:

<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>	
___	___	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

**Injuries:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Medications:** \_\_\_\_\_

**Special Dietary Requirements related to food allergies, food intolerance or gastrointestinal disease:**

Health Insurance Carrier: \_\_\_\_\_ Group & ID #: \_\_\_\_\_

Personal Physician: \_\_\_\_\_ Telephone (with area code): \_\_\_\_\_

### 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 \_\_\_\_\_ **(NAME OF CANDIDATE)**, do hereby authorize the nursing and 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 Signature                      Date                      \_\_\_\_\_ Parent \_\_\_\_\_ Guardian (check one)

**NAME** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**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.

Dates of: Td or Tdap Booster \_\_\_\_\_ MMR: \_\_\_\_\_

**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.)

	<u>NORMAL</u>	<u>ABNORMAL</u>	<u>COMMENTS</u>
1. Eyes	_____	_____	_____
2. Ears, Nose, Throat	_____	_____	_____
3. Hearing	_____	_____	_____
4. Mouth/Teeth	_____	_____	_____
5. Cardiovascular	_____	_____	_____
6. Chest/Lungs	_____	_____	_____
7. Abdomen	_____	_____	_____
8. Genitourinary	_____	_____	_____
9. Musculoskeletal	_____	_____	_____
10. Metabolic	_____	_____	_____
11. Neurological	_____	_____	_____
12. Skin	_____	_____	_____
13. Lymphatic	_____	_____	_____
14. Psychiatric	_____	_____	_____

Does this boy have any physical limitations or restrictions which would hinder his participation in Boys' State?  
Yes \_\_\_\_\_ No \_\_\_\_\_ (If yes, please explain. Attach additional sheets if necessary)

\_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_