2019 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:

YES	NO		YES	NO		YES	NO	
___	___	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 (check one)**

Parent/Guardian Signature **Date**

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.)

	NORMAL	ABNORMAL	COMMENTS
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: _____

REV 10/29/2018