2027 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 SUNY Morrisville Boys' State 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, the 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 10/5/2026