Health Screening Form

TEEN CHALLENGE OF THE MID-SOUTH, INC.
1108 W. 33rd STREET
CHATTANOOGA, TN 37410
Phone: (423) 756-5558 • Fax: (423) 265-7763

*** To Be Completed By Physician, Physician's Assistant or Nurse Practitioner ONLY! ***

Today's Date: _____

1. Name _____ D.O.B._____
2. Present Illness/Complaint/Disabilities, if any: _____

   _____
3. Allergies: _____
4. Medicine currently prescribed and reason: _____

   _____
5. Has client been exposed to any communicable diseases: Yes _____ No _____

   If yes, please specify: _____
6. History of chronic or major illness: _____

   _____
7. Operations: _____

   _____
8. Hospitalizations: _____

   _____
9. Immunizations: Last Tetanus Toxoid _____ Polio _____ Measles _____ Mumps_____

   Rubella _____ Other _____

Physical Examination

Code: Satisfactory = S Unsatisfactory = U Not Examined = O

Height _____ Weight _____ B/P _____

Pulse _____ Respirations _____ Temperature _____

Patient Name _____ Date _____

General Appearance (including schemata of drug abuse)

Nutrition _____

Head: _____

Ears _____ Hearing: R _____ L _____

Eyes _____ Vision: (without glasses) R _____ L _____

(with glasses) R _____ L _____

Nose _____ Throat _____ Mouth/Teeth _____ Neck/Thyroid _____

Chest _____ Cardiac _____ Abdomen _____ Genitalia _____

Hernia _____ Skin _____ Musculo Skeletal _____ Neurologic _____

Required Lab Tests (for Male & Female)
Attach computer printout of all test results

- Hepatitis B _____ , Hepatitis C _____
- H.I.V. _____
- TB _____ **This test must be done within 30 days prior to entering program**
- Pregnancy _____ (female only)

General comments, assessments, and recommendations on above:

_____

_____

_____

Signature of Examining Physician

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Applicant Signature: _____ Date: _____