PHYSICAL EXAMINATION FORM

NAME: **DATE OF BIRTH:**

DATE OF CURRENT EXAM: **DATE OF LAST EXAM:**

CURRENT ADDRESS:

BRIEF MEDICAL HISTORY:

ALLERGIES:

Current Prescribed Medications/Diagnosis/Dosage/Special Instructions:

LIMITATIONS/RESTRICTIONS FOR ACTIVITIES AND/OR DIET:

HEIGHT: **WEIGHT:**

VISUAL ACUITY: ___ Normal ___ Abnormal

HEARING (Audiometry or Equivalent): ___ Normal ___ Abnormal

EMERGENCY MEDICAL INFORMATION:

MEDICAL SCREENINGS

MEDICAL SCREENING	NORMAL	ABNORMAL
Eyes		
Ears/Nose		
Mouth/Throat		
Lungs		
Cardiovascular		
Abdomen		
Genitalia/Breasts		
Extremities/Joints		
Spine		
Skin/Lymph Nodes		

BLOOD PRESSURE: ___ Normal ___ Abnormal

ANY COMMUNICABLE DISEASES OR INFECTIONS: ___ Yes ___ No
Please Specify:

MANTOUX TUBERCULIN TEST
(Needed every two years for those attending the Elcam Community Center day program.)
Date Given: _____ Results: _____ If Positive, Date X-Ray Given: _____
Results:

ASSESSMENT OF DISABILITIES (Mental, Emotional, and Physical):

TREATMENT/RECOMMENDATIONS:

DIAGNOSES: Primary:
Secondary:
Tertiary:

IMMUNIZATIONS (Given Within the **Ten Years**)

VACCINE	**DATE**
Diphtheria/Tetanus/Pertussis	
Trivalent Oral Polio Vaccine	
Measles	
Mumps	
Rubella	
Diphtheria	
Tetanus	
Other	

RECOMMENDED FURTHER MEDICAL TESTS OR EXAMINATIONS:

OTHER PERTINENT INFORMATION:

PHYSICIAN INFORMATION

Physician's Signature:
Printed Name Of Physician:
Date:
Physician's Address:
Physician's Telephone Number:

INFORMATION COMPLETED BY SUPPORTS COORDINATOR

Is there a diagnosis of mental retardation? ___ Yes ___ No	**Is there a mental health diagnosis?** ___ Yes ___ No
Full Scale IQ Score:	Specify:
Type of Assessment:	Type of Assessment:
Date of Assessment:	Date of Assessment:
Completed by:	Completed by:
Agency:	Agency:
Supports Coordinator's Signature:	
IF RETURNED BY FAX: **(814) 834-1560**	**IF RETURNED BY MAIL:** 189 West Creek Road, St. Marys, PA 15857