



MEDICAL FORM
TO BE FILLED OUT BY PHYSICIAN

Patient Name: _____ Phone # _____
Medical Insurance Co.: _____ Policy # _____

This examination should be performed within six months of the specified program.

Immunization History

___ Normal ___ If not normal, please specify: _____

When was your patient's last tetanus shot? _____

Code: S-Satisfactory	X-Not Satisfactory	O-Not Examined
Eyes _____	Extremities _____	Skin _____
B.P. _____	Glasses _____	HgbTest _____
Ears _____	Nose _____	Urinalysis _____
Heart _____	Lungs _____	Teeth _____
		Hernia _____

Hgt. _____ Wt. _____

Allergy: Please specify: _____

General Appraisal: _____

(For Women) Has this person menstruated? _____ If not has she been told about it? _____
If so, is her menstrual history normal? _____

Recommendations and Restrictions while overseas:

Special Diet _____

Special Medicine (name) _____

What is the medication for? _____

Strenuous Activity _____

Eating Disorders _____

Behavioral Disorders (please specify) _____

Other _____

I have examined this person herein described and have reviewed his/her health history. It is my opinion that he/she is physically and mentally able to engage in all activities, except as noted above.

Physician Name (please print) Examining Physician Signature Date _____

Address _____ City _____

State _____ Zip _____ Telephone _____