Revelation of Freedom Ministries
Medical History and Physical Examination Form

Name: _____

Birth date: _____ Social Security #: _____

1. The following lab work is **REQUIRED** for admission to the program and copies included at the time of entrance:

   RPR – Reactive or Non-reactive (circle one) Date read: _____

   Liver Function tests – Date read: _____

   Hepatitis Screening, if indicated, based on history or abnormal liver function test results

   Hepatitis A - Positive or Negative (Circle one)

   Hepatitis B - Positive or Negative (Circle one)

   Hepatitis C - Positive or Negative (Circle one)

2. TB testing is **MANDATORY** and results included should be no older than 6 months prior to admission to the Training Center. Tetanus shot must be up-to-date with documentation or date given.

   Tuberculin Test / PPD Date: _____ Size: _____

   Chest X-Ray: _____

   Tetanus Toxoid Date: _____

3. Immunizations should be up-to-date and include:

   Measles _____ Mumps _____ Rubella _____
   Date Performed Date Performed Date Performed

4. Significant Medical Conditions:

CONDITION	YES	NO	If YES, please explain.
Asthma			
Cardiac			
Chemical Dependency			
Drugs			
Alcohol			
Diabetes Mellitus			
Gastrointestinal Disorder			
Hearing Disorder			
Hypertension			
Neuromuscular Disorder			
Orthopedic Condition			
Respiratory Illness			
Seizure Disorder			
Skin Disorder			
Vision Disorder			
Other (specify)			

***IMPORTANT: PYSICIAN MUST COMPLETELY FILL-OUT BOTH PAGES OF THIS FORM -- EVERY SINGLE LINE!!**

5. Current / routine medications:

Medication	Dosage/Use
1)	
2)	
3)	
4)	

6. Please list any allergies you have to any medications, foods, or other substances: _____

_____

_____

7. Report of Physical Examination

	Normal	Abnormal	If Abnormal, please explain…
Height (Inches)			
Weight (Pounds)			
Temperature			
Pulse			
Blood Pressure			
Hair/Scalp			
Skin			
Eyes—Visual Activity			
Eyes—Color Vision			
Hearing			
Nose and Throat			
Teeth and Gingival			
Lymph Glands			
Heart—Murmur, etc.			
Lungs—Adventurous Findings			
Abdomen			
Genitalia			
Neuromuscular System			
Extremities			
Spine (Presence of Scoliosis)			

8. Physician's observations and comments (be specific): _____

_____

_____

9. General appearance: _____

_____

Name of Examiner *(please print)* Address

_____

Signature of Physician Date of Examination

Form will be rejected if examiner's title and address are illegible.