Teen Challenge of Kentucky
Priscilla's Place
APPLICANT'S HEALTH SCREENING FORM

Return to: 1151 E Broadway, Louisville, KY 40204, ATTN: Intake Coordinator
Phone: (502) 561-2131 Fax: (502) 561-2132

****This form must be completed by a physician****

I am applying for admittance into the Teen Challenge of Kentucky residential discipleship program. In order to complete my application, I need a doctor to complete the following form regarding my health. I give permission and authorize you to release the information requested below to Teen Challenge of Kentucky. After completion, this form is to be mailed or faxed to the center.

_____ _____
Applicant's Signature *Date*

General Information

1. Name of Applicant:_____ 2. Date of Birth:_____

3. Any Allergies:_____
_____

4. Any Current Medical Conditions/Concerns:_____
_____
_____
_____

5. Medication currently prescribed, the reason for the medication, and the duration of its use: _____
_____
_____

6. History of major illness:_____
_____
_____

7. History of Surgeries/Hospitalizations:_____
_____
_____

8. Has this individual been exposed to any communicable diseases? Yes_____ No _____
If yes, please explain:_____

9. Immunization dates: Last Tetanus Toxoid _____ Polio _____ Measles _____
Mumps _____ Rubella _____ Other _____

Physical Examination

Height:_____Weight:_____ Blood Pressure:_____

Pulse:_____ Respirations:_____ Temperature:_____

General Appearance (including schemata of drug use):_____
_____
_____

Please check the following areas:

S = satisfactory U = unsatisfactory O = not examined

1. Check for head lice: _____ **does not** have head lice _____ **does** have head lice

2. Check ears: _____ Hearing: Right: _____ Left: _____

3. Check eyes: _____ Vision: Right: _____ Left: _____ Has Glasses? _____

4. Check the following areas: Nose: _____ Throat: _____ Mouth/Teeth: _____ Chest: _____

Cardiac: _____ Abdomen: _____ Genitalia: _____ Skin: _____ Scabies: _____

Musculoskeletal:_____ Neurologic:_____

Required Tests

VDRL:_____

Hepatitis Screening:
A_____
B_____
C_____

**TB:_____
Urinalysis:_____
Pregnancy:_____
Pap Smear:_____

Liver Function:_____
HIV:_____
CBC:_____

**TB results must be within 30 days of entry.

Attach/Fax/Mail a printout of all test results

General comments, assessments, and recommendations:_____
_____
_____
_____

Signature of Examining Physician: _____ Date:_____

Address: _____
_____

Phone:_____
Fax:_____