Karen's Place
Women's Teen Challenge Center
P.O. Box 686 Louisa, KY 41230
(606) 638-0938 fax (606) 826-0144

Applicant's Health Screening Form

This form must be completed by your doctor

I am applying for admittance into the Karen's Place Teen Challenge 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 Karen's Place Teen Challenge Center. 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 it's 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. Immunizations (dates): Last Tetanus Toxoid ___________ Polio _____________ Measles _________
Mumps ___________ Rubella ____________ Other ______________________

Physical Examination

Height:____________Weight:_______________ Blood Pressure:____________

Pulse:_____________ Respirations:___________ Temperature:________________

General Appearance (including skymata 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:______

   Musculo-Skeletal:_______________ 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 computer print out of all test results

General comments, assessments, and recommendations:____

____

____

Signature of Examining Physician: ___________________________________ **Date:**________________

Address: _____________________________________

____

____

Phone:_____________________________

Fax:_______________________________