

# TEEN CHALLENGE PHYSICAL EXAMINATION FORM

Student's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Sex: Male Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_ Pulse: \_\_\_\_\_

Medication (list all medications the student is currently taking):

Medication	Dose	Indication

Examination	Normal	Ab-normal	Not Done	Abnormality Description
Head, Eyes, Ears, Nose, Throat				
Neck				
Cardiovascular System				
Respiratory System				
Abdomen				
Skin				
Extremities				
Neurological System				
Mulculoskeletal System				
Rectal				
Urogenital System				

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Required lab testing for Teen Challenge students:

*(Blood and Urine tests)*

HIV	Pregnancy Test
Chlamydia	Gonorrhea
Hepatitis B	Syphilis
Hepatitis C	
TB Test	

Food allergies? Yes No \_\_\_\_\_

Type of reaction \_\_\_\_\_

Drug allergies? Yes No \_\_\_\_\_

Type of reaction \_\_\_\_\_

Are there any medical conditions that may endanger the health of the staff or students in our residential program?

Yes No Condition \_\_\_\_\_

Is there any reason why this applicant should not assist in the preparation of food in our residential program?

Yes No Condition \_\_\_\_\_

Physician's Printed Name: \_\_\_\_\_ Date of Physical Exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Physician's Signature: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

I authorize the release of the physical examination information contained on this form and laboratory test results to Teen Challenge. I also authorize the physician who performed the physical examination and/or his/her staff to discuss my medical condition with Teen Challenge.

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Please send this completed form and laboratory reports to: Kansas City Girls Academy  
5506 Cambridge Ave.  
Kansas City, Mo. 64129  
Phone: (816) 924-6565  
Fax: (816)924-6575  
Email: [kcca.admissions@teenchallenge.com](mailto:kcca.admissions@teenchallenge.com)