



## PRE-ENTRANCE PHYSICAL EXAM - WOMEN

First Name	Middle	Last
Current Address		Phone number where to reach you ( )
City/Town	Postal Code/ZIP	Date of Birth:      Month      Day      Year
Health Card #		Province of Health Card:

1. Medications currently prescribed and reasons for use: \_\_\_\_\_

2. Does the applicant currently suffer from any of the following:  
**Diabetes:** Yes No    **Allergies:** Yes No    **Asthma:** Yes No    **High Blood Pressure:** Yes No    **Heart Problems:** Yes No  
 If yes, please explain \_\_\_\_\_

3. Does the applicant have any physical limitation that would hinder her from doing normal physical labour:  Yes  No  
 If yes, please explain \_\_\_\_\_

4. Does the applicant currently suffer from any of the following mental illnesses?  
**Schizophrenia:**  Yes  No    **Bi-Polar:**  Yes  No    **ADD:** Yes No    **Other:** \_\_\_\_\_  
 If yes, please explain: \_\_\_\_\_

5. Does the applicant have any life threatening allergies? Yes No  
 If yes, please explain: \_\_\_\_\_

6. Does the applicant have any non-life threatening allergies? Yes No  
 If yes, please explain: \_\_\_\_\_

7. General Appearance and Development (include signs of drug abuse)  
 Skin: \_\_\_\_\_  
 Nutrition: \_\_\_\_\_  
 Head: \_\_\_\_\_

Ears L _____ R _____	Hearing L _____ R _____	Eyes L _____ R _____	Vision w/o Glasses L _____ R _____	Vision w/ glasses L _____ R _____
Nose	Neck/Thyroid	Throat	Mouth/Teeth	Cardiac
Abdomen	Breast	Genitalia	Hernia	Musculo/Skeletal

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 Examining Physician's Name: \_\_\_\_\_ Examination Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_

Physicians Signature: \_\_\_\_\_



## REQUIRED LAB WORK - WOMEN

First Name	Middle	Last
Health Card #	Version Code	Province of Health Card:

**Tuberculin Test:**

Date Test Given: \_\_\_\_\_ Date Checked: \_\_\_\_\_  
 Test Results: Positive Negative

**STD Testing:** All testing is required. We also require copies of lab work.

**Syphilis:** Positive Negative  
**Gonorrhea:** Positive Negative  
**Herpes:** Positive Negative  
**Hepatitis**  
**A** Positive Negative  
**B** Positive Negative  
**C** Positive Negative  
**HIV** Positive Negative

**Pregnancy Test:** Positive Negative

**Drug Screening:** We also require copies of lab work.  
 Test Results: Positive Negative

I \_\_\_\_\_, hereby grant permission for my blood transcripts to be faxed directly to the Teen Challenge Intake Office at (604) 864-4269 \_\_\_\_\_.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

This is to confirm that the above tests have been completed and/or requested and will be faxed directly to the Teen Challenge Centre you have applied to.

Physician's Name: \_\_\_\_\_  
 Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_