

Physical Examination Form



Permission to Release Information: For the purpose of determining my/my child's need for support and physical assistance, I authorize the release of any medical information by the below physician to The Woodlands Foundation, Inc.

Signature of Parent - or Applicant (if over 18)

Date

Name of Applicant: Last: _____ **First:** _____ **Middle:** _____

Birth date: _____ **Age:** _____ **Gender:** _____ **Weight:** _____ **Date of Exam:** _____

Medical Diagnosis: Primary: _____

Secondary: _____

Check if Abnormal:

- | | | | | | | |
|------------------------------------|---------------------------------|-----------------------------------|---|--|--------------------------------------|--|
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Ears | <input type="checkbox"/> Nose | <input type="checkbox"/> Throat | <input type="checkbox"/> Mouth | <input type="checkbox"/> Neck | <input type="checkbox"/> Spine |
| <input type="checkbox"/> Lungs | <input type="checkbox"/> Heart | <input type="checkbox"/> Arteries | <input type="checkbox"/> Veins | <input type="checkbox"/> Lymphatic | <input type="checkbox"/> Extremities | <input type="checkbox"/> Abdomen |
| <input type="checkbox"/> Hernia(s) | <input type="checkbox"/> Rectal | <input type="checkbox"/> Skin | <input type="checkbox"/> Genitalia-Male | <input type="checkbox"/> Gynecological | <input type="checkbox"/> Breasts | <input type="checkbox"/> Muscular-Skeletal |

Describe Abnormalities: _____

Decubitus No Yes **Location:** _____

Treatment: _____

Specific Physician Orders:

Medications: _____

Diet: _____

Allergies: _____

Activity Restrictions: _____

Ongoing Treatments: _____

Physician's Recommendations:

- In the event of an emergency, the patient can vacate the building with No Assistance Minimal Assistance Total Assistance
- Patient is capable of administering his/her own medications. Yes No With Supervision
- On the basis of the present medical findings, does the patient have any restrictions for "camps and retreats" or other recreational activities including (but not limited to) sports, swimming, camping, other physical activities?
 No Yes (Describe) _____

Attending Physician: _____ **Physician License No.** _____

Office Address: _____ **Phone:** _____

Physician (Printed Name)

Physician Signature

Date