

## INSTRUCTION SHEET

The following forms are to be filled out **only after your application has been approved and you have been accepted and given an entry date**. You will be prompted by the intake coordinator to fill them out and send them in.

- “Physical Exam Form” and “Health History”: Take these forms with you when you have your physical. Have the doctor fill each of them out. You may mail or fax the forms to us once the doctor has filled them out. When your lab results come in, you may send them to us yourself or you can sign a release at the doctor’s office giving them permission to fax the results directly to us.
- “Offer of Individual Health Insurance Coverage”: After completing this form, you must have it notarized. This form cannot be faxed. You must mail us the original.

If you have questions regarding these forms, please call (515) 282-5249 or reach us by fax at (515) 288-3920.



Updated 6-25-07

PHYSICAL EXAM FORM

Name: \_\_\_\_\_ Date of Physical: \_\_\_\_\_

Signature Signifying Release: \_\_\_\_\_ Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex:  Male  Female

Below line for medical staff use only

Fax or send this form & the lab results to:

Teen Challenge of the Midlands
1709 10th Street
Des Moines, Iowa 50314
(515) 282-5249 phone
(515) 288-3920 fax

Required Lab Results:

Written result

TB: \_\_\_\_\_
Hepatitis A,B, & C: \_\_\_\_\_
HIV: \_\_\_\_\_
CBC: \_\_\_\_\_
Tetanus Status: \_\_\_\_\_
Pregnancy Test: \_\_\_\_\_
(all females)
PAP test: \_\_\_\_\_
(all females)

Height: \_\_\_\_\_ Weight: \_\_\_\_\_
Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_
Ambulatory: \_\_\_\_\_ Non-Ambulatory: \_\_\_\_\_

Please circle any conditions requiring further medical treatment:

Eyes Dental Extremities Lymph Abdomen
Ears Neck Bones/joints Lungs Vascular Back
Nose Thyroid Neurological Heart Genitals
Throat Skin Rectal

Comments: \_\_\_\_\_

Medications (list all medications the applicant is currently taking):

1. \_\_\_\_\_ Reason prescribed \_\_\_\_\_
2. \_\_\_\_\_ Reason prescribed \_\_\_\_\_
3. \_\_\_\_\_ Reason prescribed \_\_\_\_\_
4. \_\_\_\_\_ Reason prescribed \_\_\_\_\_

Does any medical condition exist that would endanger the health of the staff or students in our program?

Yes \_\_\_\_\_ No \_\_\_\_\_ Reason: \_\_\_\_\_

Is there any reason why this applicant should not assist in the preparation of food or medical services?

Yes \_\_\_\_\_ No \_\_\_\_\_ Reason: \_\_\_\_\_

## HEALTH HISTORY

Allergies: _____	Ever been withdrawn from alcohol? _____
Diet: _____	Ever been withdrawn from chemicals? _____
Glasses: _____	How many times in detox? _____
Contacts: _____	How many times in outpatient Tx? _____
Dentures: _____	How many times in inpatient Tx? _____
Hearing Aid: _____	Date of last use: _____

	Yes	No		Yes	No
Headaches	_____	_____	Freq. Earaches	_____	_____
Difficulty Seeing	_____	_____	Freq. Colds	_____	_____
Dizziness	_____	_____	Sinusitis	_____	_____
Shortness of breath	_____	_____	Chest Pain	_____	_____
Numbness of hands, etc.	_____	_____	Palpitations	_____	_____
Chronic cough	_____	_____	Diabetes	_____	_____
Seizures	_____	_____	Cancer	_____	_____
Hallucinations	_____	_____	Tuberculosis	_____	_____
Arthritis	_____	_____	Blood Disorder	_____	_____
History of High Blood Pressure	_____	_____	Vomiting	_____	_____
Dental Problems	_____	_____	Diarrhea	_____	_____
Heartburn	_____	_____	Constipation	_____	_____
Abdominal Cramps	_____	_____	Hemorrhoids	_____	_____
Loss of Appetite	_____	_____	Weight Loss	_____	_____
Induced Vomiting	_____	_____	Starvation	_____	_____
Compulsive Eating	_____	_____	Nausea	_____	_____
Eating Disorders	_____	_____	Jaundice	_____	_____
Liver Disease	_____	_____	Dry Skin	_____	_____
Black, Tarry Stools	_____	_____	Anemia	_____	_____
Bleeding Gums	_____	_____	Freq. Urination	_____	_____
Skin Problems	_____	_____	Painful Urination	_____	_____
Slow Healing	_____	_____	Unusual Discharge	_____	_____
Athletes Foot	_____	_____	STD	_____	_____
Bruise Easily	_____	_____	Burning with Urination	_____	_____
Rashes	_____	_____	Blood in Urine	_____	_____
Lice/Crabs	_____	_____	Hx of Infection	_____	_____

**Physician's name (please print)**

**Physician's Signature**

Name of Practice: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## OFFER OF INDIVIDUAL HEALTH INSURANCE COVERAGE

**Teen Challenge of the Midlands has found a health insurance policy that is available for students. Following are details:**

- An individual health insurance policy is available through Blue Cross/Blue Shield – Wellmark, Alliance Select Enhanced.
- The policy contract exists solely between you (the student) and Blue Cross/Blue Shield – Wellmark, Alliance Select Enhanced. Teen Challenge of the Midlands is not associated with this agreement, specifically or implicitly.
- Medical coverage is independent of participation in Teen Challenge. Should you leave the program, coverage continues as long as the premium is paid. Your application for health insurance is subject to underwriting for existing conditions to determine insurability.

In light of the above, I (the student) knowingly and voluntarily:

- Accept the major medical policy as offered and agree to pay all premiums.
- Decline the major medical policy as offered. By declining this coverage, I understand that obtaining other coverage for medical expenditures is MY responsibility.

Regardless of my selection above, I acknowledge that I will be personally responsible for ALL medical and dental bills accrued during my stay at Teen Challenge of the Midlands.

Please provide forwarding address in case medical bills are mailed to Teen Challenge.

Apt/House Number and Street: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

I certify under penalty of perjury and the laws of the State of Iowa that the forgoing statements are true and correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

State of: \_\_\_\_\_ County of: \_\_\_\_\_

Subscribed and sworn before me by: \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

Notary Public Signature and Seal: \_\_\_\_\_

My commission expires: \_\_\_\_\_