Date Sent:_____

Date Returned:_____

PHYSICIAN REPORT

(To be completed by physician)

Name _____ Weight_____ Height_____

Blood Pressure_____ Pulse_____General Appearance_____

Allergies _____

HEENT_____

Pulmonary_____

Cardiovascular_____

Gastrointestinal_____

Genitourinary_____

Date of onset of period_____ Sexual activity_____

Musculoskeletal (include fractures):_____

Skin_____

Endocrine_____

Neuropsychiatric (seizures, syncopal episodes, suicidal, or psychosomatic illnesses)_____

_____

Anemia_____ Blood transfusions_____

Current Medications_____

LABORATORY TEST RESULTS (All TESTS MUST BE COMPLETED FOR ALL AGES)

RPR_____ TB test_____ Hct._____

Urinalysis_____CT/GC Test_____HIV test_____

Hep B & C screening_____

Comments_____

Date_____ Signature_____

Address_____ Telephone_____

Shiloh Christian Children's Ranch
Attention: Matthew Harris
PO Box 606, Shelbina, MO 63468
matthewharris@shilohranch.org
PHONE: (573) 588-2191 **FAX:** (573) 588-7730