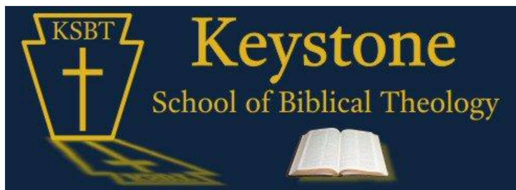

Confidential Physical Examination

Keystone School of Biblical Theology
875 Academy Drive
Lebanon, PA 17046
(717) 272-6442 Email: office@ksbt-pa.org

Name: ____ Date of Exam ____________________

1. Height ____________ Weight __________ Blood Pressure ___________ TPR __________
2. Nose/throat/sinuses ____
3. Teeth/Gums (obvious problems) ____
4. Eyes _______________ Visual Activity (20 ft.) w/glasses w/o glasses

   Is correction recommended? ___________ R_______ R_______
5. Ears ______________ Any demonstrated hearing loss? [ ] R [ ] L
6. Skin ____
7. Chest/Lungs ____
8. Heart ____
9. Abdomen: [ ] Scars [ ] Tenderness [ ] Hernia
10. Gastro intestinal tract ____
11. Genitalia ____
12. Orthopedic defects _____________________________ Posture _____________________________
13. Has student suffered from nervous or emotional disturbances? __________________________

At what age? _________ Please explain

____

____

14. State any medical treatment student is presently receiving.

____

15. What medication is student presently taking?

____

16. Has the student had any allergy or medication sensitivity?

____

17. Are there any special weaknesses or limitations?

____

18. Are there any chronic conditions that may require surgery?

____

19. Do you consider the student’s health adequate for intensive schoolwork?

____

20. Is the student able to participate in general recreational sports activities: [ ] Yes [ ] No

If no, please explain:

____

____

21. For women students: Pregnancies_________________ Menstruation difficulties _____________________

22. How long have you known the student? ____________ Years

23. Special Remarks: ____

____

____

Important Note: Please attach a complete shot record to this form. The following immunizations are considered required for enrollment to Keystone School of Biblical Theology: All DPT's, Tdap (if no tetanus booster in 5 years), 2 MMR's, 3 Hepatitis B's, 1 meningococcal, and 2 varicella (or documentation of known disease).

Doctor's Name ____

Address ____

Doctor's Signature ____

Please Stamp with Doctor's name and phone number