VICTORY OUTREACH INTERNATIONAL

Student Physical Examination Clearance Form

Personal Information

Name: _____ Date: _____
Address: _____
Phone: _____ Email: _____
DOB: ____/____/____ Sex: _____ Ethnicity: _____ Height: _____ Weight: _____
Primary Physician: _____ Phone: (_____)_____
Insurance Provider: _____ID No : _____

Student Consent for Examination and Release of Information

_____ _____
Signature of Applicant Date

For Medical Provider ONLY

Note to Physician:

The above named is/will be a student at a Victory Outreach Urban Training Center. We are interested in your medical evaluation of this person's ability to function in this capacity based upon a physical examination. In this regard would you please complete the following:

Height:		**Weight:**		**Pulse:**		**B/P:**	
Condition	Eyes	Ears	Nose	Throat	Heart	Lungs	Back
Normal							
Abnormal							

Explanation: _____
_____

Medical History

General	**YES**	**NO**	If YES, indicate the degree of function disability
Allergies			
Current Diagnosis			
Current Medications			
Previous Medications			
Current Injuries			
Previous Injurious: (e.g., sports or work related, etc..)			
Anemic/ Iron deficiency			

Medical History (continued)			
Hypertension/Hypotension			
Asthma			
Previous Medical Conditions			
Dates Treated			
Neurological	**YES**	**NO**	If YES, indicate the degree of function disability
Seizure Disorder (Epilepsy)			
Dizziness/Fainting			
Weakness/Paralysis			
Swelling of Lower Extremities			
Mental/Behavior Disorder			
Infectious Diseases	**YES**	**NO**	If YES, indicate the degree of function disability
Tuberculosis			
Hepatitis			
Mumps			
Measles			
Gonorrhea			
Syphilis			
HIV/AIDS			
FULLY VACCINATED AGAINST COVID-19			

MEDICAL PROVIDER ONLY	
Physician Name ***(Please Print)*** _____	**Phone:**
Clinic and Address:	
Signature of Examining Physician _____ _____	**Date of Exam:**