



**STUDENT MEDICAL REPORT**

This report is to be completed by a licensed practicing physician after a thorough physical examination of the student.

1. Student's Name \_\_\_\_\_

2. Student's Age \_\_\_\_\_ Sex \_\_\_\_\_

3. Name, Address, and Telephone of Examining Physician \_\_\_\_\_

To the Physician: Please complete the following:

Does the student have or show signs of the following:

1. Tuberculosis \_\_\_\_\_

2. Asthma \_\_\_\_\_

3. Epilepsy \_\_\_\_\_

4. Diabetes \_\_\_\_\_

5. Hypertension \_\_\_\_\_

6. Allergies \_\_\_\_\_

7. Depression \_\_\_\_\_

8. Psychosis \_\_\_\_\_

9. Any other mental illness \_\_\_\_\_

10. Other Communicable diseases \_\_\_\_\_

11. Any other illness that may impact on his or her ability to successfully undertake rigorous medical training. \_\_\_\_\_

12. Any additional Comments \_\_\_\_\_

Examining Physician \_\_\_\_\_

Board Certification(s) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_