Participant's Name (Last, First)_____

DOB_____ Gender Indentity_____

**Medical Examination**

This report must be based on an exam completed by an approved medical professional (MD, DO, ARNP) within twelve (12) months of arrival at the program (June 26, 2024). This report helps us to determine the saftely for this participant to engage in First Stamp LLC activies.

Height _____(in) Weight _____ (lbs) Corrective lenses Yes No (circle one)

**Allergies**

Known drug, food, insect or environmental allergies Yes No (circle one)

(If yes, please provide details including any anaphylactic reactions and also provide any relevant allergy action plans)

_____

_____

**General**

| | Within Normal Range | | Comments (required if No is circled) |
|---|---|---|---|
| Eyes, Ears, Nose +Throat | YES | NO | _____ |
| Lymph nodes | YES | NO | _____ |
| Heart sounds (murmurs) | YES | NO | _____ |
| Lung sounds | YES | NO | _____ |
| Abdomen (palpation) | YES | NO | _____ |
| Genitourinary | YES | NO | _____ |
| Musculoskeletal | YES | NO | _____ |
| Skin (scars, rashes) | YES | NO | _____ |
| General neurological | YES | NO | _____ |

**Significant Past & Present Medical History**

*(Please explain "yes" answers on a back page or attach documentation)*

| | | |
|---|---|---|
| Prescribed medications? | YES | NO |
| Medication discontinued prior to summer? | YES | NO |
| Restrictions to swimming or strenuous activity? | YES | NO |
| Restrictions regarding exposure to sun or high heat? | YES | NO |
| Any surgeries? | YES | NO |
| Any signifcant injuries? | YES | NO |
| Any concussions? | YES | NO |

**Signficant Past & Present Psychiatric History**

*(Please explain "yes" answers on a back page or attach documentation)*

| | | |
|---|---|---|
| Current in treatment by a psychiatrist or behaviroal health professional? | YES | NO |
| Partcipant in psychological therapy? | YES | NO |
| History of drug or alcohol related problem? | YES | NO |
| History of self-mutilation? | YES | NO |
| History of suicidal ideation or suicide? | YES | NO |
| Treated by psychiatrist/behaivoral health professional any time in the last 4 years? | YES | NO |

_____ _____ _____

Examining Physican/NP/PA Signature Print Date

_____ _____

Address City/State/Zip Phone

Stamp here for medical office authorization: