



Participant's Name (Last, First) _____

DOB _____ Gender Identity _____

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. This report helps us to determine the safety for this participant to engage in First Stamp LLC activities.

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 significant injuries?	YES	NO
Any concussions?	YES	NO

Significant Past & Present Psychiatric History

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

Current in treatment by a psychiatrist or behavioral health professional?	YES	NO
Participant 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/behavioral health professional any time in the last 4 years?	YES	NO

Examining Physician/NP/PA Signature	Print	Date
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Address	City/State/Zip	Phone
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Stamp here for medical office authorization: