

PHYSICAL EXAMINATION

This Physical Examination Form must be completed and signed by a Licensed Physician. It must be dated no later than 24 months prior to departure date. It must be in our office one month prior to the applicant's involvement in Ventures Travel, LLC trip.

Name _____ Date of Birth ____/____/____ Male____ Female____
 Last First Middle Initial

Diagnosis: _____

Is any condition present, which may result in an emergency? Please describe: _____

EXAMINATION COMPLETED BY DOCTOR

Height:	Weight:	Ideal Body Weight:
Pulse:	BP:	Temp: °
Head/Scalp:		Lungs:
Eyes:		Cardiac:
Vision:		Upper Extremities:
Ears/Hearing:		Lower Extremities/Edema/Circulation:
Mouth/Throat/Nose:		Back/Spine:
Neck/Thyroid & Lymph Sys:		Perineum:
Nervous System/Pupil Reaction/Reflexes/Gait/Sensations:		Skin:
Abdomen:		Breast Exam: _____ Pap Smear Performed: _____
		Testes Exam: _____
		Free from communicable disease: YES / NO
PREVIOUS ILLNESS (give age when these occurred): Chicken Pox _____ Measles _____		
Mumps _____ Scarlet Fever _____ Other _____		
IMMUNIZATION HISTORY: Please give dates (month/year) of immunizations and most recent booster dates:		
Diphtheria, Pertussis (Whooping Cough), Tetanus (DPT) _____ Tetanus Booster (required) _____		
Mumps _____ Measles _____ Rubella _____ Polio _____ TB test _____		
Hemphilus Influenza b (HIB) _____ Hepatitis b (date series completed) _____ Smallpox _____		

Is client currently receiving: Physical Therapy _____ Speech Therapy _____ Psychological Therapy _____
 Other Therapy _____ (please describe): _____
 What signs and symptoms would the client present, that would result in the need for a referral to another health care provider _____

ACTIVITY RESTRICTIONS:

**List any conditions, operations or known serious injury that may affect activity level: _____

**Are there any medical reasons to limit or restrict this individual from swimming? Yes _____ No _____
 If Yes, please explain _____

**Please list any other activity restrictions while individual is participating in a Ventures Travel, LLC trip. _____

Does applicant require daily skilled nursing care? Yes _____ No _____
 In the past year, has this client's health status changed? Yes _____ No _____ If Yes, please describe _____

Is this client on medication? Yes _____ No _____
 Please list any routine medications NOT necessary during the service period: _____

Examining Physician's Name (please print) _____
 Signature _____ Date _____
 Address _____ Phone (____) _____
 City/State/Zip _____

NOTE: IN THE EVENT OF ILLNESS, INJURY OR OTHER HEALTH/MEDICATOIN CHANGES AFTER THIS FORM IS COMPLETED, PLEASE CALL THE DIRECTOR/MANAGER AT 952-852-0107 TO DETERMINE CONTINUED ELIGIBILITY.