

New Tribes Bible Institute

PHYSICAL EXAMINATION

PLEASE HAVE YOUR PHYSICIAN COMPLETE THE PHYSICAL EXAMINATION

Name _____ Birthplace _____ Sex: M F
 Date of Exam _____ Height _____ In. Weight _____ lbs. B.P. _____ / _____ Pulse _____

CHECK EACH ITEM IN THE APPROPRIATE COLUMN

Note: Describe any abnormality.

Normal?
 YES NO

<input type="checkbox"/>	<input type="checkbox"/>	General appearance
<input type="checkbox"/>	<input type="checkbox"/>	Emotional and mental state
<input type="checkbox"/>	<input type="checkbox"/>	Eyes: Left 20/ _____ Right 20/ _____
<input type="checkbox"/>	<input type="checkbox"/>	E.N.T. and Hearing (grossly)
<input type="checkbox"/>	<input type="checkbox"/>	Teeth
<input type="checkbox"/>	<input type="checkbox"/>	Lymph nodes
<input type="checkbox"/>	<input type="checkbox"/>	Breasts
<input type="checkbox"/>	<input type="checkbox"/>	Chest
<input type="checkbox"/>	<input type="checkbox"/>	Heart S ₁ S ₂ Rhythm Murmurs? Yes No
		Rate after exercise (e.g. 20 step ups) After 2 minute rest
<input type="checkbox"/>	<input type="checkbox"/>	Vascular
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	Genitals Pelvic done? No Yes
<input type="checkbox"/>	<input type="checkbox"/>	Rectal (if over 35 y.o.) done? No Yes
<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal
<input type="checkbox"/>	<input type="checkbox"/>	Neurological
<input type="checkbox"/>	<input type="checkbox"/>	Dermatological
<input type="checkbox"/>	<input type="checkbox"/>	Other findings?

IN YOUR PROFESSIONAL OPINION, IS THE APPLICANT:

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Mentally and emotionally stable?
<input type="checkbox"/>	<input type="checkbox"/>	Capable of normal school life?
<input type="checkbox"/>	<input type="checkbox"/>	Capable of participation in sports?
<input type="checkbox"/>	<input type="checkbox"/>	Capable of strenuous physical work?
<input type="checkbox"/>	<input type="checkbox"/>	Free of communicable diseases?
<input type="checkbox"/>	<input type="checkbox"/>	ANY LAB WORK ORDERED? If yes, attach reports.
<input type="checkbox"/>	<input type="checkbox"/>	ANY ADDITIONAL COMMENT?

HOW LONG HAVE YOU KNOWN THE APPLICANT? _____

Physician's Signature and Professional Degree _____
 Physician's Printed Name and Address: _____

Please mail completed form and copy of any lab results to: New Tribes Bible Institute, Admissions Department
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 Jackson, MI 49201
 Tel. 517-782-9309 Fax. 517-782-1884