

# BOARDERS MEDICAL FORM



## TO BE COMPLETED BY MEDICAL PRACTITIONER

STUDENT'S FULL NAME

GIVEN NAMES \_\_\_\_\_ SURNAME \_\_\_\_\_

### GENERAL OBSERVATION AND PHYSICAL EXAMINATION

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BP \_\_\_\_\_ PULSE \_\_\_\_\_

**Please tick ONLY if an abnormality is detected**

**Please comment or attach documentation**

- Ear, Nose and Throat  \_\_\_\_\_
- Respiratory System  \_\_\_\_\_
- Cardio-Vascular System  \_\_\_\_\_
- Central Nervous System  \_\_\_\_\_
- Gastrointestinal System  \_\_\_\_\_
- Musculoskeletal System  \_\_\_\_\_
- Vision / Colour Vision  \_\_\_\_\_
- Skin  \_\_\_\_\_
- Gynaecological  \_\_\_\_\_
- Urogenital System  \_\_\_\_\_
- Urinalysis  \_\_\_\_\_

Are there any surgical, medical or mental health conditions? Yes  No  If yes, please provide details below

Is there a history of concussion? Yes  No  If yes, please provide details below

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have access to the student's full history? Yes  No

How long has the student been your patient? \_\_\_\_\_

DOCTOR'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

FULL NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

