**Bloom – A Place for Girls**
Health Screening Form
PO Box 603 Buzzards Bay, MA 02532

To be completed by Physician
**MUST BE COMPLETED WITHIN 72 HOURS BEFORE INTAKE DATE**

**Student's Name:** ______________________________ **Date of Physical Exam:** ____________________________

**Date of Birth:** ____/____/____

**Physical Exam:**

**Height:** _______________ **Weight:** ______________ **B/P:** ____________________

**Pulse:** __________________ **Temp:** _________________ **Resp:** ___________________

**Vision:** (w/o corrective lenses) R _____________ L _______________
(with corrective lenses) R _____________ L _______________

**Lab Work:**

**Tuberculosis Skin Test: (must have results prior to intake) ____ Positive ____Negative**

**Drug/Alcohol Screening:** ______________________________________________________________

**Pregnancy: _____Positive _____Negative**

**Hepatitis A _______ Hepatitis B _________ Hepatitis C ____________**

**Sexually Transmitted Disease Screening:**

Gonorrhea: positive negative
Chlamydia: positive negative
HIV: positive negative
Herpes: positive negative
HPV: positive negative

- **please specify if results will be pending**

****ATTACH COMPUTER PRINTOUT(S) OF ALL TEST RESULTS****

_____________________________________________
Signature of Examining Physician

_____________________________________________
Telephone

_____________________________________________
Street Address

_____________________________________________
City, State, Zip

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