

MEDICAL HISTORY

Adult & Teen Challenge
Northern Appalachian Region

Applicant's name: _____

Mailing address: _____

Street

City

State

Zip

Phone _____

The following lab tests must be completed prior to you being admitted into the Adult and Teen Challenge program. You can mail each test result to Northern Appalachian Teen Challenge, 1877 Good Hope Pike Clarksburg, WV 26301 or have them emailed to aaron@wvteenchallenge.com.

Athletic Physical

Tuberculosis (PPD or chest x-ray)

Hepatitis B

Hepatitis C

HIV

COVID-19

We must receive the results of your athletic physical, tuberculosis test and COVID-19 test, as applicable, **before** your admission to the program and within **10 days** of your enrollment. We must receive the results of your hepatitis B, hepatitis C, and HIV tests **within 10 days** after your enrollment into the Adult and Teen Challenge program. You must sign a release at your appropriate provider's office allowing them to send your test results directly to us.

Please complete the following:

Date of Birth ___/___/___ Age ___ Height _____ Weight _____

Who is your present primary care physician? _____

His/her Phone Number: _____

If you enter our program, what provisions would be made to pay for any medical and/or dental expenses you may incur while here? _____

Please list and describe any illness, injury, or symptom that you are currently experiencing and for which you are being treated: _____

Describe any serious physical injuries you have had in the past 10 years: _____

List any prescription medications you will be required to take while in the Adult and Teen Challenge program: _____

NOTE: Because of the intensity of our program we cannot admit applicants who are required to take medication that could affect their motor senses or judgment.

List any allergies (hay fever, asthma, hives, aspirin, foods, bee stings, or other substances) you may have: _____

Do you require a special diet or have food allergies? _____ If yes, please explain: _____

When were your eyes last examined? _____ Results: [] Excellent [] Good [] Bad

Any present problems with your eyes? _____ If yes, please explain: _____

Do you wear prescription glasses? _____ Are your glasses in good condition? _____

When were your teeth last examined? _____ What were the findings? _____

Do you presently have any abscesses or infections? _____ If yes, please explain: _____

Have you ever experienced, or do you presently have a physical impairment, injury, handicap, or medical problem that may prevent you from performing manual work-related tasks while enrolled in the Training Center program? _____ If yes, please explain: _____

Have you ever received mental health treatment not related to drug or alcohol use? _____ If yes, please explain: _____

Have you ever been diagnosed with a sexually transmitted disease, HIV, or Hepatitis? _____ If yes, please explain: _____

Have you ever filed a malpractice lawsuit against any physician or medical establishment? _____

Have you been addicted to drugs and/or alcohol in the last 30 days? _____ If yes, please list them: _____

Do you feel you should be medically detoxed prior to enrolling into our program? _____

Please read carefully and sign

I, the undersigned applicant, fully confirm that the information provided herein is accurate and true to the best of my knowledge, and this application form has been completed and filled out by me in my own handwriting. I fully understand that any false or incomplete information may result in my disqualification from admission into or continuation in the program.

Applicant's Signature Date

Witness' signature Date

Witness' printed name