PHYSICIAN'S REPORT ON PHYSICAL HEALTH OF APPLICANT

Lutheran Counseling & Family Services

INSTRUCTIONS	
Physician: Please complete the following form for the person referred to as "applicant" and mail to: ATTN: Kathryn Feiertag Lutheran Counseling & Family Services 3800 N. Mayfair Road Wauwatosa, WI 53222	**Applicant**: Please print and sign your name as proof that you consent to your physician sending this completed form to LCFS. Print Name:_____ Signature: _____

CURRENT HEALTH STATUS			
Date of Exam:		Length of Time Known to Physician:	
General Appearance:			
Weight:	Height:	Blood Pressure:	Pulse:
Heart:		Lungs:	
Abdomen:		Extremities:	
Hearing:		Vision:	
Mouth & Pharynx:		Thyroid:	

LABORATORY TESTS		
TB test and/or X-ray	Date:	Results:
Urinalysis	Date:	Results:
Hemoglobin	Date:	Results:

ANY HISTORY OF:	
Substance Dependency:	Diabetes:
Cardiac Disease:	Cancer:
Mental Illness:	STDs:
Neurological Disorders:	Tuberculosis:

ADDITIONAL INFORMATION
Diseases, injuries, surgeries, disabilities, or medical conditions not referred to above:
Medication currently prescribed; dosage and purpose:
Based upon a medical examination performed within the previous six months, does this person have any illness or disability that is likely to threaten the health of children or interfere with the person's capacity to provide care? ❒ Yes ❒ No

SIGNATURE	
Physician's Signature:	Date:
Physician's Name (Please Print):	
Address:	