Bloom
A Place For Girls
A Ministry of Teen Challenge New England, Inc.

TEEN CHALLENGE NEW ENGLAND / BLOOM
MEDICAL SCREENING FORM

To be completed by physician

Name: **Date of Exam:**

Physical Exam: **DOB:**

Height	Weight	Blood Pressure	Pulse	Temperature	Resp

Lab Work:

Tuberculosis Skin Test: **_____ Positive** **_____ Negative**
*(**Must** be administered and read immediately prior to intake)*

Pregnancy: **_____ Positive** **_____ Negative** **_____ Pending (not reqd)**

Hepatitis C: **_____ Positive** **_____ Negative** **_____ Pending * (if avail)**

HIV : **_____ Positive** **_____ Negative** **_____ Pending * (if avail)**

COVID19 **_____ Positive** **_____ Negative**
*(**Must** have results read prior to intake or provide proof of immunization)*

***** Please attach computer printout(s) of all test results.*****

_____ _____
Signature of Examining Physician **Telephone**

_____
Street Address **City, State, Zip**

Med HP FILE