



Student Health Record

PHYSICIAN'S REPORT OF HEALTH EVALUATION

To the Examining Physician: Please review the student's report and complete this physician's form, with comments on all positive answers. Since this student has already been accepted for admission, the information supplied will not affect his or her status and will be used only as background for providing any needed care by the Student Health and Counseling Services. It will not be released without the student's consent. **This form should be given to the student, who will return it to the College.**

Name _____ Gender Female Male
Last First Middle

Blood Pressure _____ Height _____ inches

Urinalysis (if indicated) Sugar _____ Albumin _____ Micro _____ Weight _____ pounds

Hemoglobin (if indicated) _____ gms.

Are there any abnormalities of the following systems?

	Yes	No	Describe fully
Head, Ears, Nose, or Throat			
Respiratory			
Cardiovascular			
Hernia			
Eyes			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			

Is there loss or seriously impaired function of an organ? Yes No
 Explanation _____

Recommendations for physical activity/athletics: Unlimited Limited
 Explanation _____

Do you have any recommendations regarding the care of this student? Yes No
 If so, what? _____

Is the patient now under treatment for any medical condition? Yes No
 Diagnosis _____

Has the student been under the care of a medical specialist? Yes No
 If so, please list any medical restrictions. _____

Is the patient now under treatment for any psychological condition? Yes No
 Diagnosis _____

General comments? _____

Physician's Signature _____

Address _____

Last Name Printed _____

Date _____

Medications (please list below)

Allergies (please list below)

Immunizations REQUIRED

Measles/Mumps/Rubella **Dates**
(must have two MMRs)

Dose #1 [month/day/year] _____

Dose #2 [month/day/year] _____

Tetanus/Diphtheria/Tdap _____
(must be within 10 yrs)

Meningococcal _____
(must be within 5 years)

Chicken Pox/Varicella _____
State if had disease

Tuberculin Skin Test

Complete online TB Evaluation/Screening Form to determine if you will need a TB skin test. If the answer is yes, download that form and have physician complete.

Immunizations RECOMMENDED

Hepatitis B First _____
 Second _____
 Third _____

Gardasil/HPV First _____
 Second _____
 Third _____

Hepatitis A First _____
 Second _____