

STUDENT COMPLETES

Name: _____
Last First Middle SSN

Address: _____
Number and Street City State Zip

Sex: F M Date of Birth: _____ Marital Status: _____ No. of Children: _____

Telephone: _____ Citizenship: _____

Parent(s) Name(s): _____

Parent(s) Home Phone (s): _____ Parent(s) Work Phone(s): _____

Medical Insurance Company: _____ Group No. _____ Policy No. _____

Person to contact in case of an emergency: _____ Phone Number: _____

Are you a Military Veteran? Yes No Date of Discharge: _____ Are you a Military Dependent? Yes No

Year of Enrollment: _____ Attending: Full-time Part-time

If previously attended Hellenic College, please give the semester and year of last attendance: _____

HEALTH CARE PROVIDER COMPLETES

Tetanus-Diphtheria	Hepatitis B	Measles (Rubeola) after 1980	Mumps	Rubella (German Measles)
Immunization: _____ <small>Date within 10 years</small>	1 st Immunization: _____ AND _____ Date	1 st Immunization: _____ AND _____ Date	Immunization: _____ OR _____ Date	Immunization: _____ OR _____ Date
PPD Skin Test: _____ <small>Mantoux within past 12 months</small> Date	2 nd Immunization: _____ AND _____ Date	2 nd Immunization: _____ OR after 1980 _____ Date	Date of Disease: _____ OR _____ Date	Date of Disease: _____ OR _____ Date
Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive	3 rd Immunization: _____ Date	Date of Disease: _____ OR _____ Date	Immune Titer: _____ Date	Immune Titer: _____ Date
	Result of Titer _____	Result of Titer _____	Result of Titer _____	Result of Titer _____

Other Immunizations

Meningococcal Vaccination: _____ Date Given: _____
 _____ Date Given: _____
 _____ Date Given: _____

All Students Under Age 19
 Polio: Completed primary series only: Date Given: _____

If PPD results are positive, a chest x-ray is required

Chest X-Ray (full-sized, posteroanterior) for Tuberculosis screening

_____ Date Result: Negative Positive

 Signature, address and date of physician or other health care provider authenticating immunizations. (Please place physician or health care provider address or stamp above.)

STUDENT OR PARENT COMPLETES

FOR ALL STUDENTS UNDER 18 YEARS OF AGE: I authorize the Hellenic College/Holy Cross Health Center to administer medical and surgical services, immunizations, and therapeutic procedures as deemed necessary by duly licensed personnel. Every reasonable effort will be made to contact the parents of a student under the age of 18 before such services are administered.

 Parent's or Guardian's Signature Date

FOR ALL STUDENTS: By signature, I verify that the information provided on this form is true and I give permission for such diagnostic, therapeutic, and operative procedures as may be deemed necessary for me.

 Student's Signature Date

STUDENT COMPLETES

Last Name _____ First Name _____ Middle _____ SSN _____

MEDICAL HISTORY

HAVE YOU HAD?	Y	N	HAVE YOU HAD?	Y	N	HAVE YOU HAD?	Y	N	HAVE YOU HAD?	Y	N
Chicken Pox			Recurrent Headaches			Bleeding Disorder			Allergy:		
Back Injury			Appendicitis			Bone or Joint Disease			Penicillin		
Scarlet Fever			Sinusitis			Chronic Cough			Sulfa		
Hepatitis			Recurrent Colds			Epilepsy			Codeine		
Measles (Rubeola)			Ear/Nose/Throat Trouble			Eye Trouble			Aspirin		
Head Injury			Tuberculosis			Heart Trouble			Wasp/Bee Stings		
Hernia			Menstrual Disorder			Irregular Sleep Patterns			Foods (which)		
German Measles (Rubella)			Frequent Anxiety			Kidney/Bladder Disease			Other Allergies:		
Infectious Mononucleosis			High/Low Blood Pressure			Pain/Pressure in Chest					
Polio			Psychotic Episode			Recent Weight Change			Surgery:		
Mumps			Frequent Depression			Recurrent Diarrhea			Appendectomy		
Peptic Ulcer			Eating Disorder			Shortness of Breath			Tonsillectomy		
Asthma			Diabetes			Stomach Trouble			Hernia Repair		
Seizures/Blackouts			Cancer			Venereal Disease			Other Surgeries:		
Arthritis			Hearing Difficulty			Dizziness, Fainting					
Have you received treatment or counseling for an anxiety condition, personality or character disorder, or emotional problem?						Give details					

HEALTH CARE PROVIDER COMPLETES

PHYSICAL EXAMINATION (Required for all full-time undergraduate students)

Temperature _____ Blood Pressure _____ Pulse _____ Height _____ Weight _____

CHECK - normal	Y	N		Y	N		Y	N	If answer is "NO" explain below
Development			Tonsils			Abdomen			
Posture			Neck			Genitalia			
Skin			Thyroid			Upper extremity			
Ears			Chest			Lower extremity			
Eyes			Heart			Bones and joints			
Nose			Lungs			Feet			
Mouth			Breasts						

Vision (without glasses) Right _____ Left _____ (with glasses) Right _____ Left _____

Routine Urinalysis _____ Albumin _____ Sugar _____ Microscopic _____

1. Current medications (please list):

2. Activity limitations?

3. Is patient ready to undertake college activities? Yes No If "no" please explain. _____

Comments: _____

Signed: _____ Date: _____

Physician Signature

Address: _____ Phone: _____