



STATEMENT OF MEDICAL EXAM & IMMUNIZATION

NAME _____ SEX _____ AGE _____ DOB _____

ADDRESS _____

MEDICAL HISTORY:

1. List ANY chronic/serious diseases you have or had.

2. List any previous hospitalizations or operations.

3. List any handicaps or allergies you have (including medicines)

4. List any regular medications or diet restrictions.

5. If the student is receiving therapy, please give details.

6. Has the student been treated for any of the following diseases or conditions? Y or N

_____ Tuberculosis	_____ Heart, kidney or liver disorder
_____ Epilepsy	_____ STD
_____ Asthma	_____ Diabetes
_____ Hypertension	_____ Other

Physical Examination

1. Height _____ 2. Weight _____ 3. Blood Pressure _____

United Tribes



Technical College

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4. Please note any abnormal findings regarding:

- Head and neck _____
- Eyes, Ears, Nose, Throat _____
- Cardiovascular _____
- Abdomen _____
- Skin _____
- Nervous System _____
- Extremities _____

5. Is this student physically capable of carrying a full college program?

6. If you are aware of any emotional, psychological, or personal difficulties which may limit the student's ability to fulfill the demands of college life, please explain.

7. Please verify measles, mumps & rubella is up to date.

MMR #1 date received _____

MMR #2 date received _____

8. Other comments:

Certification by Physician

I certify that the information provided above is complete and accurate to the best of knowledge.

Physician: _____

Name (print)

Signature

Date