VALOR CHRISTIAN COLLEGE

Medical Information Form

Please fill out the first two sections and then present this form to a medical doctor.

A ***COMPLETE*** examination is required.

GENERAL INFORMATION

Classification				Enrollment Date		Attendance		Housing	
New Freshman				Fall '20		Full-time		Residence Hall	
Transfer (request transcripts from other colleges/universities attended)				Spring '20		Part-time		Commuter	
Re-Activation	Dates of Last Attendance	Date:		Summer '20					
Continuing Ed Student				Other					

HEALTH HISTORY

PERSONAL INFORMATION

Name:______________________________ Social Security No.______________
Last First M.I. Maiden

Address:______________________________ Gender: ______________
Street Apt.

______________________________ Marital Status: ______________
City State Zip

Daytime Phone: ______________ Evening Phone: ______________ Date of Birth: ______________

Name of Parent or Guardian:______________________________

Address of Parent or Guardian: ______________________________
Street Apt.

______________________________ Phone: ______________
City State Zip

FAMILY MEDICAL HISTORY

Have any of your relatives had any of the following diseases/disorders? If yes, please explain relationship to you.

Epilepsy	Yes		No		Relationship	
Cancer	Yes		No		Relationship	
Diabetes	Yes		No		Relationship	
Tuberculosis	Yes		No		Relationship	
Heart Disease	Yes		No		Relationship	
Mental Illness	Yes		No		Relationship	
Migraine Headaches	Yes		No		Relationship	

PERSONAL HISTORY

Have you ever experienced any of the following? If yes, give approximate age.

Mumps	Yes		No		Age		Allergies	Yes		No		Age		Emotional Illness	Yes		No		Age	
Anemia	Yes		No		Age		Appendicitis	Yes		No		Age		Mononucleosis	Yes		No		Age	
Asthma	Yes		No		Age		Tonsillitis	Yes		No		Age		Use of Tobacco	Yes		No		Age	
Malaria	Yes		No		Age		Convulsions	Yes		No		Age		Use of Drugs	Yes		No		Age	
Measles	Yes		No		Age		Chicken Pox	Yes		No		Age		Use of Alcohol	Yes		No		Age	
Diabetes	Yes		No		Age		Tuberculosis	Yes		No		Age		Regular Use of Tranquilizers	Yes		No		Age	
Jaundice	Yes		No		Age		Heart Disease	Yes		No		Age		Regular Use of Diet Pills	Yes		No		Age	
Impaired Sight	Yes		No		Age		Draining Ears	Yes		No		Age		Scarlet Fever	Yes		No		Age	
Pneumonia	Yes		No		Age		Whooping Cough	Yes		No		Age		Typhoid Fever	Yes		No		Age	
Diphtheria	Yes		No		Age		Rheumatic Fever	Yes		No		Age		Hapatitis B	Yes		No		Age	

Other illness(es) or severe injuries:

List any surgeries you have undergone in the past 5 years:

GENERAL PHYSICAL INFORMATION
(The following sections must be completed by your physician.)

PHYSICIAN: Please provide the following information about the applicant.

MEASUREMENTS	
Height	
Weight	
Blood Pressure	
Temperature	
VITAL SIGNS	
Pulse Rate	

CLINICAL EVALUATION: (Describe every abnormality in the space provided below.)										
Head, Face, Neck	Normal		Abnormal		Abdomen	Normal		Abnormal	
Thyroid	Normal		Abnormal		Extremities	Normal		Abnormal	
Scalp	Normal		Abnormal		Skin	Normal		Abnormal	
Eyes	Normal		Abnormal		Neurological	Normal		Abnormal	
Ears	Normal		Abnormal		Muscular System	Normal		Abnormal	
Nose and Sinuses	Normal		Abnormal		Endocrine	Normal		Abnormal	
Mouth, Teeth, Throat	Normal		Abnormal		Genitalia	Normal		Abnormal	
Chest and Lungs	Normal		Abnormal		Breast Exam	Normal		Abnormal	

Explanations: ____

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TEST RESULTS: *(Must be complete and up-to-date.)*	
Results of PPD Skin Test (Day & Year)	
HCT	
Urinalysis	
Chest X-ray required for positive PPD	Results

IMMUNIZATIONS: *(Each applicant must have the following immunizations up-to-date.)*	
Initial MMR Date (Month & Year)	
MMR Booster Date (Month & Year)	
Poliomyelitis Sabin	
Hepatitis B	
Tetanus	
*A Measles Titer is required if you have had measles.	Results

MISCELLANEOUS MEDICAL INFORMATION					
1. Are you personally acquainted with the applicant's medical history?		Yes		No	
2. List any known allergies, including drug sensitivities.					
3. Is the applicant now receiving medication that you advise continuing?		Yes		No	
If yes, please indicate which medications.					
4. Is there any reason that the applicant should be limited in a regular education program?		Yes		No	
Has the applicant ever been restricted in a physical program before?		Yes		No	
If yes, please explain.					
5. Are there any additional problems that should be called to our attention?		Yes		No	
6. Do you consider the applicant physically and emotionally capable of participating in intensive academic work plus part-time employment, should that be necessary?		Yes		No	

Name of Physician: ______________________ Signature: ______________________

Address: ____
Street City State Zip

Phone: ____________ Date of Examination: ____________

Please send this form directly to: