# ST. LOUIS CHRISTIAN COLLEGE

# HEALTH FORM

Please print:

Semester: ☐ Spring ☐ Fall Year _____

Name: _____ Social Security #: ____-____-_____

Address _____

City/State/Zip: _____

Telephone: (_____) _____ Date of Birth: _____/_____/_____

Person to be notified in emergency: _____ Relationship: _____

Address:_____

Phone: (_____) _____

TO BE COMPLETED FOR ALL ATHLETES AND RESIDENTIAL STUDENTS*

**TO BE COMPLETED BY A PHYSICIAN** DATE: _____

Name and Title:_____

Street Address: _____

City/State/ Zip: _____

PATIENT INFORMATION

Height _____ Weight _____ Pulse _____ Blood Pressure _____ Respiration _____

Head _____ Eyes _____ Ears _____ Nose _____ Mouth/Throat _____ Neck _____

Lymphatics _____ Chest/ Lungs _____ Heart _____ Breasts _____ Abdomen _____

Rectal _____ GU Male _____ GYN _____ Extremities _____ Back _____ Skin _____

Neurologic _____ Hernia _____ Joints _____

Lab Work: HGB _____ W.B.C (if indicated) _____ Urine _____

TB Test: Positive _____ Negative _____ Date: _____

In your opinion, is this applicant physically qualified for a FULL academic life, including an active sports program? ( ) Yes ( ) No

Signature: _____ Date: _____

*Please schedule an appointment for a physical with a physician immediately because it may be difficult to obtain on short notice.

(Continued on the next page)

TO BE COMPLETED BY ALL STUDENTS

1. ILLNESS

Check the ☐ If you have had any of the following.

Check the ○ If a **close blood relative** has had any of the following.

| | | |
|---|---|---|
| ☐ ○ Alcoholism | ☐ ○ Lung Disease | ☐ ○ High blood pressure |
| ☐ ○ Anemia | ☐ ○ Epilepsy, Seizures | ☐ ○ Ulcer in stomach/duodenum |
| ☐ ○ Asthma | ☐ ○ Stroke | ☐ ○ Psychological Disorder |
| ☐ ○ Bleeds Easily | ☐ ○ Heart Disease | ☐ ○ Nervous Breakdown |
| ☐ ○ Drug Abuse | ☐ ○ Suicide Attempt | ☐ ○ Mumps, measles, chicken pox |
| ☐ ○ Depression | ☐ ○ Diabetes | ☐ ○ Rheumatic Fever |
| ☐ ○ Hives | ☐ ○ Thyroid Disease | ☐ ○ Polio |
| ☐ ○ Liver Disease, Hepatitis | ☐ ○ Venereal Disease | ☐ ○ Malaria |
| ☐ ○ Yellow Jaundice | ☐ ○ Cancer, Tumor | |

If anyone in your family has had any of the above illnesses, please list the relationship to you and describe the extent of the illness:

_____

_____

_____

2. HOSPITALIZATIONS/ SURGERY: List major operations and injuries within an approximate year. Please include all pregnancies.

_____

_____

3. MEDICINES YOU ARE TAKING: List medicines, birth control pills, or vitamins you take with or without a prescription.

If asthmatic, list any MDIs you take and precipitants (i.e. what brings on your attack).

| | | |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

4. ALLERGIES: List any allergies you may have, including food and medicine.

| | | |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

5. IMMUNIZATIONS: Check those you have had. Note most recent year received.

| | | | |
|---|---|---|---|
| ☐ Flu _____ | ☐ Tetanus/ _____ | ☐ Diphtheria _____ | ☐ Varicella (or antibody) _____ |
| ☐ Polio _____ | ☐ M.R._____ | ☐ Hepatitis B _____ | ☐ Meningococcal _____ |

The information contained in this form will be held in the strictest confidence!

**I certify that the information contained in this form is correct to the best of my knowledge.**

**Name: _____ Date: _____**