



Medical Information Form

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

A **COMPLETE** examination is required. **PLEASE TYPE OR PRINT**

GENERAL INFORMATION

CLASSIFICATION (check one)

- New Freshman
 Transfer (Also request transcripts from other colleges and universities attended)
 Re-Activation
 Dates of Last Attendance _____

- Continuing Ed Student (non-degree)

ENROLLMENT DATE (check one)

- Fall 20 _____
 Spring 20 _____
 Summer 20 _____
 Other _____

ATTENDANCE (check one)

- Full-time (12+ hrs.)
 Part-time (up to 11.5 hrs.)

HOUSING (check one)

- Residence Hall
 Commuter

HEALTH HISTORY

PERSONAL INFORMATION

Name: _____ Social Security No. _____ - _____ - _____
 Last First M.I. Maiden

Address: _____ Gender: _____
 Street Apt.

City State Zip Marital Status: _____

Daytime Phone: (____) _____ Evening Phone: (____) _____ Date of Birth: _____

Name of Parent or Guardian: _____

Address of Parent or Guardian: _____
 Street Apt.

City State Zip Phone: (____) _____

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

	Yes	No	Relationship		Yes	No	Relationship
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____				

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

	Yes	No	Age		Yes	No	Age
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	_____	Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Emotional Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Measles	<input type="checkbox"/>	<input type="checkbox"/>	_____	Use of Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Use of Drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	_____	Use of Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Impaired Sight	<input type="checkbox"/>	<input type="checkbox"/>	_____	Regular Use of Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Regular Use of Diet Pills	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	_____	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	Typhoid Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other illness(es) or sever injuries:			_____
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	_____				_____
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	_____				_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____				_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____				_____
Draining Ears	<input type="checkbox"/>	<input type="checkbox"/>	_____				_____

List any surgeries you have undergone in the past five (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: _____ / _____ Vital Signs: Pulse Rate _____
Temperature _____

CLINICAL EVALUATION: (Describe every abnormality in the space provided below.)

Head, Face, Neck	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Abdomen	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Thyroid	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Extremities	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Scalp	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Skin	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Eyes	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Neurological	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Ears	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Muscular System	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Nose and Sinuses	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Endocrine	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Mouth, Teeth, Throat	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Genitalia	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Chest and Lungs	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Breast Exam	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

Explanations: _____

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) _____
Tetanus _____
Polio myelitis Sabin _____
Hepatitis B _____

*A Measles Titre 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? _____
Has the applicant ever been restricted in a physical program before? _____ If yes, please explain. _____
5. Are there any additional problems that should be called to our attention? _____
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:

Valor Christian College
Office of Admissions
P.O. Box 800
Columbus, OH 43216-0800
(614) 837-4088 • 1-800-940-9422 • Fax (614) 837-6904