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.

_____ 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.

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

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

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

Other illness(es) or sever injuries: _____

_____

_____

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	❒ 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: _____

_____

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 _____
Poliomyelitis 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