



**ST. MARY'S COLLEGE**  
200 East Mission Street  
Saint Marys, Kansas 66536  
(785) 437-2471

*Rev. Fr. Patrick Rutledge, Rector*  
*Dr. Joseph Strong, Academic Dean*

## MEDICAL FORM

\_\_\_\_\_  
Student's Last Name                      First Name                      Middle  
Gender \_\_\_\_\_ Date of Birth (mm/dd/yyyy) \_\_\_\_\_ SSN \_\_\_\_\_  
Address \_\_\_\_\_

\_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Country \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_  
Parent/Legal guardian \_\_\_\_\_  
Address (if different than above) \_\_\_\_\_

\_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Country \_\_\_\_\_  
Phone: (home) (\_\_\_\_) \_\_\_\_\_ (cell) (\_\_\_\_) \_\_\_\_\_ (work) (\_\_\_\_) \_\_\_\_\_

### Health History

<i>Does this student:</i>	No	Yes	(if yes, please explain)
1) See a physician regularly for illness or health problems?	_____	_____	_____
2) Have a history of hospitalization?	_____	_____	_____
3) Have a history of childhood diseases?	_____	_____	_____
4) Take medication on a regular basis?	_____	_____	_____
5) Have vision, speech, or hearing problems?	_____	_____	_____
6) Have a history of mental illness?	_____	_____	_____
7) Have a history of emotional problems?	_____	_____	_____
8) Require any special assistance in school?	_____	_____	_____
9) Suffer from any chronic illness or condition?	_____	_____	_____
10) Have any allergies, including those to certain foods?	_____	_____	_____
11) Have an immunization record?      No _____ Yes: DTP and/or TD ( o 1 2 3 4 5 ); Oral Polio ( o 1 2 3 4 5 ) MMR ( o 1 ); Other/additional explanation _____			
12) Please provide any additional health information or explanation: _____			

## Physical Examination Form

Name \_\_\_\_\_ DOB \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ Vision: R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected (Y/N)

	<i>Normal</i>	<i>Abnormal Findings</i>
<b>MEDICAL</b>		
<i>Appearance</i>		
<i>EENT</i>		
<i>Hearing</i>		
<i>Lymph nodes</i>		
<i>Heart</i>		
<i>Murmurs</i>		
<i>Pulses</i>		
<i>Lungs</i>		
<i>Abdomen</i>		
<i>GU (males only)</i>		
<i>Skin</i>		
<b>MUSCULOSKELETAL</b>		
<i>Neck</i>		
<i>Back</i>		
<i>Shoulder / arm</i>		
<i>Elbow / forearm</i>		
<i>Wrist/ hand /fingers</i>		
<i>Hip / thigh</i>		
<i>Knee</i>		
<i>Leg / ankle</i>		
<i>Foot / toes</i>		

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of Physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of Physician \_\_\_\_\_, MD / DO