



St. Mary's College

MEDICAL FORM

Personal Information:

Student's Last Name _____ First Name _____ Middle _____

Gender _____ Date of Birth (mm/dd/yyyy) _____ SSN _____

Home Address _____

City _____ State _____ Zip Code _____ Country _____

Phone: (____) _____ E-mail _____

Parent, Legal Guardian or Emergency Contact Information

Name _____ Relation _____

Address (if different than above) _____

City _____ State _____ Zip Code _____ Country _____

Phone: (primary) (____) _____ (secondary) (____) _____

Health History

Does this student:

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 (0 1 2 3 4 5); Oral Polio (0 1 2 3 4 5)

MMR (0 1);

Other/additional explanation:

12. Please provide any additional health information or explanation:



St. Mary's College

Physical Examination Form

Name _____ DOB _____

Height _____ Weight _____ Pulse _____ BP _____ / _____ Vision R 20/ _____ L 20/ _____ Corrected? (Y/N)

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

Notes:

Print Name of Physician _____ Date _____

Address _____ phone _____

Signature of Physician _____ MD / DO