FAIRMONT STATE HEALTH FORM

HEALTH AND ACCIDENT INSURANCE

____
(Name of Company)

TO BE COMPLETED BY STUDENT

Name: ______________________
(Last) (First) (Middle)

Age: ____ Sex: M F Date of Birth ________ Place of Birth: ________

Date of Examination: ________________ Class: F SO J SE Other

Do you consider yourself in good health? ________________

If not, what is your complaint? ________________

Have you had, or do you now have (check yes or no)

	Yes	No		Yes	No
Scarlet fever			Mental disease		
Diphtheria			Paralysis		
Rheumatic Fever			Epilepsy		
Measles			Kidney desease		
Mumps			Heart disease		
Chickenpox			Pneumonia		
Whooping cough			Tuberculosis		
Hay Fever			Pleurisy		
Asthma			High blood presure		
Allergies			Digestive trouble		
Diabetes			Shortness of breath		
Hernia			Running ears		
Appendicitis			Recent weight loss		
Fainting spells			Bone or joint disease		
Nervous disease			Knee disorder		
Deafness			Skin disease		
Acne			Family History of Tuberculosis		
Menstrual difficulties			Family History of Diabetes		
			Family History of Mental disease		
Any other serious illness	Yes	No	Describe		
Any operations	Yes	No	Describe		
Any broken bones	Yes	No	Describe		

Indicate whether you have received the following inoculations or tests

	Yes	No	Year		Yes	No	Result
DPT							
MMR				Tuberculin test			
POLIO				Chest X-ray			

Fairmont Address: ________________ Phone: ________

Home Address: ________________ Phone: ________

Parent or Guardian: ________________ Phone: ________

Family Physician: ________________

TO BE COMPLETED BY PHYSICIAN

Height ______, Weight ______ , Present B.P.______ , Pulse ______

	N	Abn.	Abnormalities below
Teeth			
Eyes			
Ears			
Nose			
Tongue			
Throat			
Thyroid			
Tonsils			
Neck			
Glands			
Heart			
Lungs			
Breasts			
Abdomen			
Hernia			
Extremities			
Feet			
Knee jerk			
Skin			
Neurological			

Urine—Sp. Gr.________ Alb. ________ Sug. ________ Micros.________

Required:

- ❑ Tetanus toxoid (within four years of Registration)
- ❑ Tuberculin test (if positive, chest x-ray and report)

Students may be eligible for rehabilitation - Please list corectable defects:

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______________________ M.D.

Return to: Office of Admissions

FAIRMONT STATE

Physical Examination Form

NOTE: Students admitted to Fairmont State must have this form executed by a physician. The form is to be submitted to the Office of Admissions. The information on all health forms will be released to Fairmont State's Student Health Services.

	Date	Report
1. Required prior to admissoin:		
A. Tine or PPB Test	__________	__________
B. Chest X-Ray (if Tine positive)	__________	__________
C. Hepatitis Test (HAA or HBAIG or similar)	__________	__________
D. Serology (RPR or VDRL or Similiar)	__________	__________
E. Tetanus Toxoid	__________	__________
F. MMR or Immune Rubella Titer	__________	__________
II. RECOMMENDED anytime prior to admission:		
Hepatovax	__________	__________

III. Record any of the conditions listed below:

A. Speech defect

B. Hearing loss

C. Visual loss

D. Orthopedic abnormality

IV. Is there any known physical or emotional condition which would interfere with completing a Fairmont State program? ____________________

V. Record any medication now being taken: ____________________

OTHER COMMENTS: ____________________

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____________________ Name of Student

____________________ Signature of M.D.

____________________ Date of Examination