EDUCATION THAT WORKS
ForsythTech
COMMUNITY COLLEGE

REPORT OF MEDICAL HISTORY

PLEASE COMPLETE THIS SIDE BEFORE GOING TO YOUR PHYSICIAN FOR EXAMINATION

LAST NAME (Print) FIRST NAME MIDDLE . TELEPHONE NUMBER

HOME ADDRESS (NUMBER & STREET) CITY STATE ZIP CODE COUNTRY

DATE OF BIRTH M☐ F☐ SEX SINGLE ☐ MARRIED ☐ OTHER ☐ MARITAL STATUS

_____YES ☐_ NO ☐_____ PREVIOUSLY ENROLLED HERE? FALL ☐__ SPRING ☐ SUMMER_☐___ _____ PROPOSED DATE OF REGISTRATION YEAR

NAME OF HEALTH INSURANCE COMPANY COMPANY ADDRESS & PHONE NUMBER POLICY NUMBER

NAME & RELATIONSHIP OF NEXT OF KIN

ADDRESS OF NEXT OF KIN PHONE NUMBER

PARENTS OF STUDENTS UNDER 18: I hereby authorize any medical Treatment for my son/daughter which may be advised or recommended.

SIGNATURE OF PARENT OR GUARDIAN DATE

Have any of your relatives had any of the following?

	Yes	NO	Relationship
Tuberculosis			
Diabetes			
Heart Disease			
Kidney Disease			
Arthritis			
Stomach Disease			
Asthma or Hay Fever			
Epilepsy, Convulsions			

PERSONAL HISTORY: PLEASE ANSWER ALL QUESTIONS Comment on all positive answers in space below or on additional sheet.

HAVE YOU HAD	YES	NO		YES	NO		YES	NO		YES	NO
Eye Trouble			Frequent or Severe Respiratory infections			Kidney or Bladder Disease			Diabetes		
Ear, Nose, Throat Trouble									Infectious Mononucleosis		
Frequent or Severe Headaches			Rheumatic Fever or Heart Murmur			Disease or Injury of Bones or Joints					
Epilepsy			Stomach or Intestinal Trouble			"Trick" Knee, Shoulder, etc.			FEMALES ONLY		
Asthma, Hay Fever, Hives									Irregular Periods		
Tuberculosis			Hepatitis or Jaundice			Anemia			Severe Cramps		
									Excessive Flow		

	Yes	No
A. Do you have any disease, or is any drug or other treatment being followed which should be continued or periodically evaluated? (Give details)		
B. Have you any drug allergy or other known sensitivity or intolerance? (Give details)		
C. Have you had any illness, injury, or operation, or been hospitalized other than as already noted? (Give details)		
D. Has your physical activity been restricted during the past five years? (Give reasons and duration)		
E. Have you ever been hospitalized for mental or emotional illness? (Give name(s) and address(es) of doctor(s) and hospital(s))		
F. Have you ever interrupted school or work either because of mental or emotional illness or alter psychiatric consultation? (Give details and doctor(s) name(s) and address(es))		
G. Have you been tested for the HIV/AIDS virus?		

REMARKS OR ADDITIONAL INFORMATION
(Use additional sheet if necessary)

STATEMENT BY STUDENT: I have personally supplied the above information and attest that it is true and complete to the best of my knowledge.

A photocopy of this permission is to be considered as valid as original.

Signature of Student Date

Physician's Signature (Acknowledging Review) Date

MEDICAL EXAMINATION

TO THE EXAMINING PHYSICIAN: This form MUST be completed in its ENTIRETY. Please review and sign the student's history on the front before completing the physical examination. Please comment on all positive answers. The information supplied will be used as a background for providing health care. This information is strictly for use of Forsyth Technical Community College to provide necessary services, and will not be released without the student's consent.

LAST NAME _____ FIRST NAME _____ MIDDLE _____ DATE OF BIRTH _____

Height_____Inches_____Weight_____Pounds Blood Pressure_____/_____ Pulse_____/min.

VISION: Corrected Right 20/_____ Left 20/_____ Hearing (gross):

Uncorrected Right 20/_____ Left 20/_____ Right_____ Left_____

URINALYSIS HEMATOCRIT

Sugar_____ _____%

Albumin_____

Micro_____

Tuberculin Skin Test (Required Yearly)

Date_____ Positive/Negative (circle)

Chest X-Ray/Date_____Report_____

Are there abnormalities of the following systems?

	Yes	No
1. Head, ears, nose or throat		
2. Eyes		
3. Respiratory		
4. Cardiovascular		
5. Gastrointestinal		
6. Hernia		
7. Genitourinary		
8. Musculoskeletal		
9. Metabolic/Endocrine		
10. Neuropsychiatric		
11. Skin		

A. Is there any loss or seriously impaired function of any paired organ? Yes_____ No_____

B. Have you any general comments?

_____

Immunizations Required for Admission to College

North Carolina state law requires that all new undergraduate and graduate students entering college must have certain required immunizations. Immunization records must be kept on file at the college. Students taking both day and night classes are required to present proof of immunization. Students enrolled in four semester hours or less and residing off campus are exempt from this law. Students attending night classes, weekend classes or off-campus courses only are also exempt.

HISTORY OF IMMUNIZATIONS

VACCINE	DATE	DATE	DATE	DATE	DATE
DPT					
*Td or Tetanus Booster					
Polio, oral					
**Rubeola (measles)					
Mumps					
Rubella (German Measles)					

NOTE: *Measles after 1st DOB
**TD within last 10 years

HEPATITIS B: Date_____

I do hereby give Forsyth Technical Community College permission to notify My parents/guardian in the event of an emergency.

_____
Student Signature

C. Recommendations for physical activity (Physical Education, intramural sports, etc.) Unlimited_____ Limited_____

Explain: _____

D. Do you have any recommendations regarding the care of this student? Yes_____ No_____

E. Is this student now under treatment for any medical or emotional condition? Yes_____ No_____

_____

Physician's Signature_____Date of Examination_____

Print Name_____

FOR OFFICE USE ONLY