

HEALTH CENTER MEDICAL RECORD

Student's Medical records are confidential and are kept under secure conditions. They are used only by authorized personnel for the purpose of furnishing counseling service and assistance.

STUDENT'S							
NAME							
Last First			Middle Former	Former			
ADDRESS City			State 7 in Code	7: C- 1-			
No. Street City HOME TELEPHONE NO:	D	ATE C	State Zip Code OF RIPTH SOC SEC NO				
HOME TELEFITONE NO.	D	AIL C	DI BIRTIISOC. SEC. NO				
IN CASE OF EMERGENCY NOTIFY:	PHONE:						
PERSONAL HISTORY							
CHECK AND DESCRIBE BELOW:							
CONDITION	YES	NO	CONDITION	YES	NO		
ALERGIES ASTHMA CANCER, CYSTS, TUMOR, ETC. CONVULSIONS OR EPILEPSY DIABETES DRUG HABIT EARS EYES FAINTING GASTRO-NTESTNAL	HEART INJURIES KIDNEY MUSCULO-SKELETAL NERVOUS RHEUMATIC FEVER THYROID TUBERCULOSIS VENEREAL DISEASE						
DESCRIBE ANY ITEM CHECKED YES: _ LIST ANY PREVIOUS SERIOUS ILLNESS							
2. LIST ANY PREVIOUS SERIOUS ILLNESS	ES AN	D OP	ERATIONS:				
CHECK BOX IF ANY PHYSICAL HANDICAL	PS.		/DATE				
A. □ WHEELCHAIR BOUND B. □ BLIND OR PARTIALLY SIGHTED C. □ USE BRACES AND CRUTCHES E. □ NEUROLOGICAL IMPAIRMENTS (PC) F. □ SPEECH IMPEDIMENTS	OLIO, C		BRAL PALSY, ETC.)				
DESCRIBE DISABILITY BRIEFLY:							

PHYSICAL EXAMINATION

(TO BE COMPLETED BY A LICENSED PHYSICIAN)

TUBERCULIN PPD

HEIGHT_	IN. WEIGH	TLBS.	VISION O.D	CORR.	(MAN	TOUX	TEST). DA	TE	RESULT
			O.S	CORRCI	HEST XRAY: Г	DATE:	- No1	37	_RESULT
D D	/	mmUa	DIHCE	/min			Month	Year	
В.Р.	/		PULSE	/min.					
Hgb		Gm.%							
NORMAL	ABNORMAL				REMARKS	– DESC	CRIBE ABN	ORMAI	LITIES ONLY
		HEAD & N	ECK						
		NOSE AND	SINUESE						
		MOUTH AN	ND THROAT						
		GUMS ANI	TEETH						
		EYES							
		EARS, HEA	RNG						
		CHEST, BR	EASTS, LUNGS	S					
		HEART							
		VASCULAI	R SYSTEM						
		ABDOMEN	AND VISCERA	A					
		HERNIA							
		ANUS AND	RECTUM						
		SPINE AND	MUSCULOSK	ELETAL					
		GENITO-UI	RNARY SYSTE	M					
		SPINE AND	MUSCULOSK	ELETAL					
		TATTOOS	TIFYING MAR	KS, SCARS,					
		NEUROLO	GIC						
		PSYCHIAT	RIC						
TAKING MEI SPECIFY:	NY EMOTIONAL, M DICATION: YE S NAME (PRINT)	ENTAL OR PH	IYSICAL CONDITIO	ON FOR WHICH T	HIS STUDENT IS	S UNDEI	R MEDICAL (OBSERV.	ATION AND/OR
SIGNATURE									
ADDRESS									
DATE OF EX	AMINATION:								
	NURSING Section 405.3 (b)						f <u>Physical</u> <u>F</u>	Examina	tion is required:
I ha	ive examined				on				
impairment	sed on my physics which is of poten or addiction to de	ntial risk to pa	atients or which r	might interfere v	with the perform	mance o	of his/her du	ıties, ind	
Physician's	signature	Lice	nse number	_	(PHYSICIAN	J'S ST <i>A</i>	AMP)		