



TEXAS COLLEGE
MEDICAL EXAMINATION FORM

All Information kept Confidential



Name: Last First Middle

Address: City: ST: Zip:

Telephone: () Date of Birth: Gender: M/F (Please Circle)

Name of person case of emergency: Relationship to you:

Telephone: ()

I. Record of illness: (Check those that occurred within the past five (5) years).

- Frequent Colds, Allergies, Bone Disease, Influenza, Chickenpox, Skin Disease, Bronchitis, Hernia, Diabetes, Pneumonia, Cholera, Kidney Disease, Tuberculosis, Rheumatic Fever, Other, Asthma, Specify:

II. Have you had any of the following to occur? (Check those that occurred within the past five (5) years).

- Blurred Vision, Leg Pains, Vomiting, Recurring Headaches, Palpitation, Sore Throat, Blackouts, Respiratory Problems, Abdominal Pains, Fainting Spells, Frequent Urination, Constipation, Painful Joints, Problems Urinating, Nosebleed, Backaches, Cough (prolonged), Hepatitis

III. Physical Examination (Must See A License Physician To Complete This Section):

Table with 4 columns: AREA, COMMENTS, AREA, COMMENTS. Rows include Skin, Eyes, Nasopharynx, Tonsils, Thyroid, Blood Pressure, Urine (Albumin), (Specific Gravity), Hemoglobin, Lymph Glands, Chest, Lungs, Heart, Genitalia, Pulse, Microscope, Diabetes, Allergies.

Immunization for Bacterial Meningitis: (High Importance)

Mental or Emotional Disorders:

Recommendations:

I hereby certified that this student has been examined by me and is mentally and physically able to enroll in this school.

Examining Physician's Signature

Telephone

Date

Physical Address

City/St

Zip