

Trinity College of Florida

Medical Information Form

Please fill out the top two sections and present this form to a Medical Doctor.
A COMPLETE examination is required.

PERSONAL INFORMATION

ATTENDANCE (check one)

- Full-time
 Part-time

HOUSING (check one)

- Residence Hall
 Commuter

ENROLLMENT YEAR:

- Fall _____
 Spring _____

CLASSIFICATION (check one)

- New Freshman
 Transfer
 Readmission

Date of last attendance _____

- Special Student (non-degree, audit)

Name _____ Sex: Male Female
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP

S.S.# _____ E-Mail _____ Marital Status _____

Phone Number (_____) _____ - _____ Date of Birth _____

Name of Parent or Guardian _____ Phone Number (_____) _____ - _____

Address of Parent or Guardian _____

HEALTH HISTORY

FAMILY MEDICAL HISTORY: Have any of your relatives had any of the following diseases/disorders? If yes, please explain relationship to you.

| | Yes | No | Relationship | | Yes | No | Relationship |
|--------------|--------------------------|--------------------------|--------------|--------------------|--------------------------|--------------------------|--------------|
| Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Mental Illness | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Migraine Headaches | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | |

PERSONAL MEDICAL HISTORY: Have you ever experienced any of the following? If yes, give approximate age.

| | Yes | No | Age | | Yes | No | Age | |
|----------------|--------------------------|--------------------------|-------|---------------------------------|--------------------------|--------------------------|-------|--|
| Mumps | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Whooping Cough | <input type="checkbox"/> | <input type="checkbox"/> | _____ | List any Allergies: _____ _____ |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | _____ | |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Emotional Illness | <input type="checkbox"/> | <input type="checkbox"/> | _____ | |
| Malaria | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Mononucleosis | <input type="checkbox"/> | <input type="checkbox"/> | _____ | |
| Measles | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Use of Tobacco | <input type="checkbox"/> | <input type="checkbox"/> | _____ | List any other Major Illnesses: _____ _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Use of Drugs | <input type="checkbox"/> | <input type="checkbox"/> | _____ | |
| Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Use of Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | _____ | |
| Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Regular use of Tranquilizers | <input type="checkbox"/> | <input type="checkbox"/> | _____ | List any surgeries you have undergone in the last 5 years: _____ _____ |
| Diphtheria | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Regular use of Diet Pills | <input type="checkbox"/> | <input type="checkbox"/> | _____ | |
| Appendicitis | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | | |
| Tonsillitis | <input type="checkbox"/> | <input type="checkbox"/> | _____ | List any Major Injuries: _____ | | | | |
| Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | | |
| Chicken Pox | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | | |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | | |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | | |
| Draining Ears | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | | |
| Scarlet Fever | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | | |
| Typhoid Fever | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | | |
| Impaired Sight | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | | |

PHYSICAL EXAMINATION

The following sections must be completed by your physician.

PHYSICIAN: Please give the following about the applicant.

Measurements: Height _____ Weight _____

Blood Pressure: _____ / _____

Vital Signs: Pulse Rate _____ Temperature _____

CLINICAL EVALUATION: (Describe every abnormality in the space provided below)

| | | | | | |
|----------------------|---------------------------------|-----------------------------------|-----------------|---------------------------------|-----------------------------------|
| Head, Face, Neck | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | Abdomen | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Thyroid | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | Extremities | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Scalp | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | Skin | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Eyes | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | Neurological | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Ears | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | Muscular System | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Nose and Sinuses | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | Endocrine | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Mouth, Teeth, Throat | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | Genitalia | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Chest and Lungs | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | Breast Exam | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |

Explanations: _____

TEST RESULTS: (Must be complete and up to date)

Results of PPD Skin Test (Day & Year) _____

(Chest X-Ray required for positive PPD)

HCT _____

Urinalysis _____

Results: _____

IMMUNIZATION: (Each applicant must have the following immunizations up to date)

Initial MMR Date (Month & Year) _____

(A Measles Titre is required if patient has had measles)

MMR Booster Date (Month & Year) _____

Tetanus (Month & Year) _____

Poliomyelitis Sabin (Month & Year) _____

Results: _____

MISCELLANEOUS MEDICAL INFORMATION:

Are you personally acquainted with the applicant's medical history? Yes No

List any known allergies, including drug sensitivities: _____

Is the applicant now receiving any medication that you advise continuing? _____

Is there any reason that the applicant should be limited in a regular educational program?

Has the applicant ever been restricted in a physical program before? _____ Why? _____

Are there any additional problems which should be called to our attention? _____

Females only: Are menstrual periods regular? If no, please explain: _____

Do you consider the applicant physically and emotionally capable of participating in intensive academic work plus part-time employment should that be necessary? Yes No

Name of Physician: _____

PLEASE PRINT

SIGNATURE

Address: _____

Phone Number: (_____) _____ - _____ Date of Examination: _____

Please send this form directly to:

Office of Student Development
Trinity College of Florida
2430 Welbilt Boulevard
Trinity, Florida 34655