

Date of Exam _____

1. Was a pelvic examination performed? No Yes Results: _____

2. Was a rectal examination performed? No Yes Results: _____

Fecal Occult Blood _____

3. Is there any reason this student should be restricted in any way? No Yes If yes, explain: _____

4. Does this student need to be on a special diet? No Yes If yes, what diet? _____

5. Does this student need any medical, surgical or psychiatric care or follow-up while she is a student at Midway College? No Yes If yes, explain: _____

PHYSICIAN'S SIGNATURE _____

DATE _____

MIDWAY COLLEGE

STUDENT HEALTH FORM



MIDWAY
College

Return to:
Office of Student Affairs
Midway College
512 E. Stephens St
Midway, KY 40347-1120

859-846-5390
www.midway.edu

TO THE STUDENT: All Midway College students are required to complete a Student Health Form before the housing assignment is released. The information provided is a confidential record to be used by the Campus Nurse to provide the best possible health service and care to the student. Because a completed health form and immunization record including two MMR's are required prior to registration, you and your physician should complete and return this form to: Office of Student Affairs, Midway College, 512 E. Stephens St., Midway, KY 40347-1120.

(Please Type or Print)

PART I (to be completed by the applicant)

A. 1. When do you plan to enter Midway College?

Fall Semester, 20____; Spring Semester, 20____; Summer Semester, 20____

2. What do you plan to study at Midway College? _____

3. I will be a: full-time student part-time student

4. I will be a: commuter resident

B. NAME

LAST FIRST MIDDLE

ADDRESS

STREET & NO. CITY STATE ZIP

PHONE DATE OF BIRTH SOCIAL SECURITY #

C. PERSON TO NOTIFY IN CASE OF AN EMERGENCY:

NAME PHONE HOME WORK

ADDRESS

STREET & NO. CITY STATE ZIP

D. Are you covered by health insurance? No Yes

If yes, please complete this section.

If no, Midway College provides information about an optional plan or student health insurance. Contact the Midway College Business Office for information.

TYPE OF COVERAGE _____

NAME OF COMPANY _____

NAME OF POLICY HOLDER _____

INSURANCE NUMBER _____

E. PHYSICIAN'S NAME _____

OFFICE ADDRESS _____

OFFICE PHONE _____

F. Emergency Consent: Please have your guardian complete the following:

I, _____, hereby consent for a physician selected by duly constituted officials of Midway College to perform any necessary medical or surgical (including anesthesia administration) treatment on _____ if unable to give consent, and/or under 18 years of age, and/or in case of emergency while the above named student is attending Midway College. I understand college personnel will attempt to notify me in case of an emergency.

SIGNATURE _____ DATE _____

RELATIONSHIP TO STUDENT _____

PERSONAL MEDICAL HISTORY: (Check appropriate response)

1. Do you have any allergies? No Yes If yes, please indicate: _____
2. Are you on a special diet? No Yes If yes, what type: _____
3. Are you on any routine medications? No Yes If yes, please list: _____
4. Do you wear contacts? No Yes If yes, what type of contacts? _____
5. Do you have any physical limitations? No Yes If yes, explain: _____
6. Have you ever had double vision, fainting spells, seizure disorders or recurrent severe headaches? No Yes
If yes, explain: _____
7. Have you ever had bronchitis, pneumonia, sinusitis, asthma, frequent sore throat or frequent ear infection?
No Yes If yes, explain: _____
8. Have you ever had an abnormal chest x-ray, tuberculosis or shortness of breath? No Yes If yes, explain: _____
9. Have you ever had rheumatic fever, heart murmur, circulation problems, chest pain, abnormal heart beat or high blood pressure? No Yes If yes, explain: _____
10. Have you ever had an ulcer or a disorder of the liver, gallbladder, colon or stomach? No Yes
If yes, explain: _____
11. Have you ever had a bladder, kidney or urinary tract infection? No Yes If yes, explain: _____
12. Have you ever had "sugar in the urine," diabetes, under active/overactive thyroid gland or diseases of the endocrine system? No Yes If yes, explain: _____
13. Have you ever had abnormal menstrual cycles, disorder of the ovaries or recurrent vaginal infections?
No Yes If yes, explain: _____
14. Have you ever had any broken bones, arthritis or joint injuries? No Yes If yes, explain: _____
15. Have you ever had any serious illness or been hospitalized for reasons not yet mentioned? No Yes
If yes, explain: _____

(cont'd)

16. Have you ever been to a psychiatrist or psychologist or received treatment for an emotional disorder?
No Yes If yes, explain: _____
17. Have you ever had a drug, alcohol or substance abuse problem? No Yes If yes, explain: _____
18. Does your family have any history of cancer, diabetes, tuberculosis, high blood pressure or any unusual illness? No Yes If yes, explain: _____

I verify that the preceding information is true and complete to the best of my knowledge.

STUDENT'S SIGNATURE DATE

PHYSICIAN'S SIGNATURE DATE
(ACKNOWLEDGING REVIEW)

TO THE DOCTOR: Please review the personal medical history and make any comments you deem necessary in the space provided below. Please complete all items following and detail any abnormalities in the space available. Your frank description of this student's health status will be greatly appreciated.

PART II (to be completed by a physician)

A. COMMENTS:

B. IMMUNIZATION RECORDS REQUIRED:

Tetanus toxoid (date) _____
Diphtheria (date) _____
MMR (date) #1 _____ #2 _____
Polio (date) _____

Recommended:

Hepatitis B #1 _____
#2 _____
#3 _____
Varicella _____
Meningitis (date) _____
HPV #1 _____
#2 _____
#3 _____

C. DIAGNOSTIC INFORMATION:

Height _____ Weight _____
Pulse _____ B/P _____
TB skin test: (required for ALL students) date _____ results _____
Urinalysis: glucose _____ albumin _____
Hematology: hemoglobin _____ hematocrit _____
Chest x-ray (required if TB test is positive) _____ date _____

D. PHYSICAL EXAMINATION: Please list and explain any abnormalities discovered by physical examination:

(cont'd)