

Student Health Form
Baptist College of Health Sciences
1003 Monroe Avenue
Memphis, Tennessee 38104
(901) 575-2247

Personal Information

Name _____ Resident _____ Commuter _____
SSN _____ Age _____ Sex _____ Date of Birth _____

Baptist Memorial College of Health Sciences

The pre-entrance medical report and examination are required of all students entering Baptist Memorial College of Health Sciences. This record is to be filled out and signed by your personal physician. All information is strictly confidential and is obtained for the purpose of insuring adequate health care for the student in the event of illness or emergency. Also, if there are any reasons that the student cannot participate in regular college activities, including physical education, they must be noted by the physician. We require some type of student health insurance so prompt treatment will be available as the need may arise.

Data and History (please answer each question)

Home Address _____

Date of College Entrance _____

Parent/Guardian Name _____

Parent/Guardian Business Address _____

Home Telephone _____ Business Telephone _____

Health Insurance Company _____

Policy Number _____ Telephone Number _____

In Case of Emergency, Notify _____

Relation _____ Telephone Number _____

Treatment Authorization

I hereby authorize Baptist Memorial College of Health Sciences to gain professional medical treatment for the student here mentioned in the event of an emergency, until such time as the above listed person(s) can be notified.

Student's Signature Date

Parent/Guardian Signature Date
(if student is a minor)

Part 1
Medical History

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Fracture | <input type="checkbox"/> Obstetrical Complications |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent or Severe Headache | <input type="checkbox"/> Overweight |
| <input type="checkbox"/> Hayfever | <input type="checkbox"/> Frequent Indigestion | <input type="checkbox"/> Periods of Unconsciousness |
| <input type="checkbox"/> Arthritis, Bursitis | <input type="checkbox"/> Frequent or Painful Urination | <input type="checkbox"/> Poliomyelitis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Recurrent Back Pain |
| <input type="checkbox"/> Blood in the Urine | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hemorrhoids or Rectal Disease | <input type="checkbox"/> Sugar or Albumin in Urine |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Chronic or Frequent Colds | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Coughing up Blood | <input type="checkbox"/> Positive HTLV3 AIDS | <input type="checkbox"/> Trouble Sleeping |
| <input type="checkbox"/> Cyst, Growth (tumor) | <input type="checkbox"/> Infectious Mononucleosis | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Vaginal Infection |
| <input type="checkbox"/> Ear, Nose, Throat trouble | <input type="checkbox"/> Measles (German, Rubella, Red) | <input type="checkbox"/> Vertigo or Dizziness |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Mumps | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Menstruation, Irregular, Painful | |
| <input type="checkbox"/> Eye Trouble | <input type="checkbox"/> Medication – Daily (any reason) | |

1. If you answered “yes” to any of the above, please explain.

2. Describe any serious illness or injury, which required hospitalization.

3. Have you ever had surgery? Please explain.

4. Have you ever been treated for a mental or emotional illness? Specify when, where, age, and physician.

5. Medications taken on a regular basis.

6. Allergies to Medications/Other:

Part II
Physical Examination

Date of Exam _____ Height _____ Weight _____ BP _____ Pulse _____ Temp _____

Please indicate if normal Please describe if abnormal

Head _____

EENT _____

Dental _____

Neck _____

Heart _____

Lungs _____

Abdomen, (Hernia) _____

G.I. _____

GU _____

Musculoskeletal _____

Physical or Emotional: _____

Any condition that would limit this student's activities within the Baptist College of Health Sciences? _____ No _____ Yes
If yes, explain below:

*Authorized Signature _____

Assessor's Name (Please print or type) _____

Professional Address _____

*Any licensed practitioner authorized to complete history and physicals.

Part III
Baptist College of Health Sciences
Immunization Record

A Healthcare provider must complete this form.
Or you Must supply a copy of each record listed below from the doctor or clinic performing the service.

Student's Name _____ SSN _____ Date of Birth _____

| Vaccinations | Test Date | Signature or Facility Stamp where Received | Results (if applicable) | |
|--|-----------------|---|----------------------------|----------------|
| 1. Diphtheria-Tetanus Toxoid Booster (TD due every 10 years) | _____ | _____ | _____ | |
| 2. Measles, Mumps and Rubella (MMR) <u>Mandatory one of the following</u> (Not applicable if born before January 1, 1957) | | | | |
| a. Serum antibody titers (attach copy) _____ | _____ | _____ | _____ | |
| OR | | | | |
| b. MMR | | | | |
| Dose #1 _____ | _____ | _____ | _____ | |
| Dose #2 _____ | _____ | _____ | _____ | |
| 3. Varicella (Chicken Pox) <u>Mandatory one of the following</u> if had childhood disease please select (a) | | | | |
| a. Serum antibody titer (attach copy) _____ (Varicella-Zoster AB, IGG) | _____ | _____ | _____ | |
| OR | | | | |
| b. Varicella Vaccine | | | | |
| Dose #1 _____ | _____ | _____ | _____ | |
| Dose #2 _____ | _____ | _____ | _____ | |
| 4. Documentation of Hepatitis B Series (HBV Vaccine) | | | | |
| Dose #1 _____ | _____ | _____ | _____ | |
| Dose #2 _____ | _____ | _____ | _____ | |
| Dose #3 _____ | _____ | _____ | _____ | |
| 5. If you have completed the Hepatitis B vaccine series, you must have a Hepatitis titer to show immunity (Anti-HBS): | | | | |
| Hepatitis B Surface Antibody Titer _____ | _____ | _____ | _____ | |
| (attach a copy if you already have a titer record showing immunity) | | | | |
| 6. Screening Test for Tuberculosis | Date Test Given | Type | Results | Date Test Read |
| TB Skin Test _____ | _____ | _____ | _____ | _____ |
| <u>TB Test must be completed annually to stay enrolled.</u> | | | | |

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Part IV
Statement and Consent

I certify that the information given on this form is correct, and I have no abnormality, limitation, or restriction not mentioned on this document. I understand that any false information, willful or negligent misrepresentation, or failure to disclose any requested information will constitute grounds for dismissal from BMCHS. I agree to notify BMCHS of any change in my physical or mental health, either prior to my registration, or while I am a student at the College. I acknowledge by my signature that I have read and understand these statements, and agree to be bound by them.

Signature

Date

