PHYSICAL EXAMINATION--HEALTH HISTORY

(Must be completed by a physician)

Applicant's Name: _____ Date: _____

Home Address: _____ Phone: _____

Height: _____ Weight: _____ Pulse: _____ B.P. High _____

Vision: R20/ ____ Corrected 20/ _____ Low _____

L20/ ____ Corrected 20/ _____ Normal _____

Previous Diseases (Please Check):	**Past (Date)**	**Current**	**Comments**
Asthma			
Allergies			
Bronchitis			
Diabetes			
Epilepsy			
Heart Trouble			
Migraine			
Rheumatic Fever			
Ulcers			
Have you ever been treated for or hospitalized for nervous or emotional condition?			
Have you ever been diagnosed with Corona Virus? _____ Yes _____ No If yes, give details:			
Other serious diseases or operations:			
	Normal	**Abnormal**	**Describe Abnormalities**
Eyes			
Ears			
Nose			
Throat			
Chest & Lungs			
Heart			
Abdomen			
Spine			
Extremities			
Lymphatics			
Neurological			

State any medicine or drugs to be used regularly by applicant: _____

_____

Any physical disability that will prevent student from participating in any form of physical activities or duties? Yes/No
If yes, please describe:_____

In your opinion, is applicant adaptable to dormitory living? _____

Does applicant have any communicable disease that would prevent dormitory living? _____

Examiner: _____Address: _____

Date:_____ Address: _____

PLEASE INCLUDE A COPY OF ALL IMMUNIZATIONS ON FILE FOR THIS INDIVIDUAL

TO EXAMINING PHYSICIAN: Please mail this form to:

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