FOR OFFICE USE ONLY

MR ☐	BUAL ☐
TB ☐	URINE ☐
CXR ☐	HGB ☐

MEDICAL EVALUATION

PART I

Student or Parent: Please provide the following information. All items must be completed. Please print.

IDENTIFICATION

Name: _____ (Last / First / Middle) **Birth Date:** _____ / _____ / _____ (mo / day / yr)

Address: _____ (Street / P.O. Box) **Phone:** ( ) -

_____ (City) _____ (State/Country) _____ (Zip)

EMERGENCY NOTIFICATION

Name: _____ **Relationship:** _____

Address: _____

Home Phone: ( ) - **Work Phone:** ( ) -

MEDICAL HISTORY

Please indicate which illnesses or conditions you now have or you have previously experienced. Indicate by answering yes or no. For all yes responses indicate the year of onset or occurrence.

ILLNESSES

Yes	Year	No		Yes	Year	No		Yes	Year	No	
☐	_____	☐	Anemia	☐	_____	☐	Gonorrhea	☐	_____	☐	Migrains
☐	_____	☐	Asthma	☐	_____	☐	Heart Disease	☐	_____	☐	Rubella
☐	_____	☐	Back Problems	☐	_____	☐	Hepatitis	☐	_____	☐	Suicide Attempt
☐	_____	☐	Bleeding Problem	☐	_____	☐	Hearing Problem	☐	_____	☐	Syphillis
☐	_____	☐	Cancer	☐	_____	☐	Herpes	☐	_____	☐	Thyroid Disease
☐	_____	☐	Colitis	☐	_____	☐	High Blood Pressure	☐	_____	☐	Tuberculosis
☐	_____	☐	Depression	☐	_____	☐	Hypoglycemia	☐	_____	☐	Ulcers
☐	_____	☐	Emotional Problem	☐	_____	☐	Joint Problem	☐	_____	☐	Vision Problem
☐	_____	☐	Epilepsy	☐	_____	☐	Measles	☐	_____	☐	Women: Severe Period Cramps
☐	_____	☐	Fainting Spells	☐	_____	☐	Mental Illness				

SURGERIES

Yes	Year	No		Yes	Year	No		Yes	Year	No	
☐	_____	☐	Appendectomy	☐	_____	☐	Hernia Surgery	☐	_____	☐	Spine Surgery
☐	_____	☐	Galbladder Surgery	☐	_____	☐	Knee	☐	_____	☐	Thyroid Surgery
☐	_____	☐	Others (Explain) _____								

HOSPITALIZATIONS: List all hospitalizations, within the last 10 years, expect surgeries listed above. Give year of occurrence. _____

ALLERGIES: List allergies with the reaction you experience. _____

MEDICATIONS: List name of any medications(s) you commonly take along with dose (how much you take) and frequency (how often you take it). _____

HANDICAPS: So we may help provide for your needs, please list any physical handicaps which may require special equipment or accommodations. _____

I the undersigned student (if 18years of age or older) or the parent or guardian of the above named student (if the student is 17 years of age or younger) do hereby affirm that the above information is accurate and complete. I, the undersigned, do hereby authorize, in the case of illness or injury, and diagnostic or therapeutic examination, procedure, or treatment deemed advisable by and rendered under the supervision of, the Student Health Physician or other health care providers selected by faculty, officers, or agents of **Andrews University** or selected by the undersigned. Consent is hereby granted to the Student Health Service to release pertinent medical information to the aforementioned health care providers, and to give any test and/or immunization required of University Students if such test or immunization has not been completed or documentation of completion is lacking. Such test or immunization may include but may not be limited to measles, mumps, and rubella, tetnus, tuberculosis skin test, hemoglobin, and urine for glucose and protein.

Student: _____ **Dated:** _____

Parent or Guardian: _____ **Witness:** _____

MEDICAL EVALUATION

PART II

Physician: First, review the completed medical history on the reverse side of this form, and evaluate documentation of any tests or immunizations that have already been given. Next perform the necessary tests and examinations to complete this die of the form.

Students Name: _____ **Age:** _____
Last First MI

Ht _____ **Wt** _____ **BP**_____ /_____ **Vision: O.D.** _____ /20 _____**Corrected**
O.S. _____ /20 _____**Uncorrected**

EXAMINATION

	Norm	Abn	Details
Skin			
HEENT			
Neck			
Heart			
Lungs			
Breast			
Abdomen			
Hernias			
Back			
Extrem			
Reflexes			

TESTS AND IMMUNIZATIONS

Is there documentation that the following have been competed? Please give results where appropriate.

MMR (or MR)	☐ **yes**	☐ **no**	**date** ___/___/___	
Tetnus (or DT)	☐	☐	**date**___/___/___	
TB test	☐	☐	**date** ___/___/___	**results** _____
Hemoglobin	☐	☐	**date** ___/___/___	**results** _____
Urine Glucose	☐	☐	**date** ___/___/___	**results** _____
Urine Protein	☐	☐	**date** ___/___/___	**results** _____

If the TB skin test is positive has a CXR been performed? No _____ **Yes** _____ **Date** ____/____/____
Results: Normal _____ **Other**_____

Are there any physical deformities or limitations? No _____ **Yes** _____

(if yes explain) _____

_____

_____

Are there any physical or emotional illnesses or conditions that may require ongoing medical care? No _____ **Yes** ___

(if yes explain) _____

_____

_____

Physician's Signature _____ **Date** ____/____/____

Name (Print or Stamp) _____ **Phone**_____

Address _____