Health Form

Holy Cross
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STUDENT COMPLETES

Name: _____
Last First Middle SSN

Address: _____
Number and Street City State Zip

Sex: ❒ F ❒ M Date of Birth: _____ Marital Status: _____ No. of Children: _____

Telephone: _____ Citizenship: _____

Parent(s) Name(s): _____

Parent(s) Home Phone (s): _____ Parent(s) Work Phone(s): _____

Medical Insurance Company: _____ Group No. _____ Policy No. _____

Person to contact in case of an emergency: _____ Phone Number: _____

Are you a Military Veteran? ❒ Yes ❒ No Date of Discharge: _____ Are you a Military Dependent? ❒ Yes ❒ No

Year of Enrollment: _____ Attending: ❒ Full-time ❒ Part-time

If previously attended Holy Cross, please give the semester and year of last attendance: _____

HEALTH CARE PROVIDER COMPLETES

Tetanus-Diphtheria
Immunization: _____ Date within 10 years
PPD Skin Test: _____ Mantoux Date within past 12 months
Result: ❒ Negative ❒ Positive

Hepatitis B
1st Immunization: _____ Date
AND
2nd Immunization: _____ Date
AND
3rd Immunization: _____ Date
_____ Result of Titer

Measles (Rubeola) after 1980
1st Immunization: _____ Date
AND
2nd Immunization: _____ Date
OR after 1980
Date of Disease: _____ Date
OR
Immune Titer: _____ Date
_____ Result of Titer

Mumps
Immunization: _____ Date
OR
Date of Disease: _____ Date
OR
Immune Titer: _____ Date
_____ Result of Titer

Rubella (German Measles)
Immunization: _____ Date
OR
Date of Disease: _____ Date
OR
Immune Titer: _____ Date
_____ Result of Titer

If PPD results are positive, a chest x-ray is required

Chest X-Ray (full-sized, posteroanterior) for Tuberculosis screening

_____ Result: ❒ Negative ❒ Positive
Date

Other Immunizations

Meningococcal Vaccination: Date Given: _____
_____ Date Given: _____
_____ Date Given: _____

_____
Signature, address and date of physician or other health care provider authenticating immunizations. (Please place physician or health care provider address or stamp above.)

FOR ALL STUDENTS: By signature, I verify that the information provided on this form is true and I give permission for such diagnostic, therapeutic, and operative procedures as may be deemed necessary for me.

_____
Student's Signature Date

IMPORTANT: Make a copy of this form for your personal records.

STUDENT COMPLETES

Last Name _____ First Name _____ Middle _____ SSN _____

MEDICAL HISTORY

HAVE YOU HAD?	Y	N	HAVE YOU HAD?	Y	N	HAVE YOU HAD?	Y	N	HAVE YOU HAD?	Y	N
Chicken Pox			Recurrent Headaches			Bleeding Disorder			Allergy:		
Back Injury			Appendicitis			Bone or Joint Disease			Penicillin		
Scarlet Fever			Sinusitis			Chronic Cough			Sulfa		
Hepatitis			Recurrent Colds			Epilepsy			Codeine		
Measles (Rubeola)			Ear/Nose/Throat Trouble			Eye Trouble			Aspirin		
Head Injury			Tuberculosis			Heart Trouble			Wasp/Bee Stings		
Hernia			Menstrual Disorder			Irregular Sleep Patterns			Foods (which)		
German Measles (Rubella)			Frequent Anxiety			Kidney/Bladder Disease			Other Allergies:		
Infectious Mononucleosis			High/Low Blood Pressure			Pain/Pressure in Chest					
Polio			Psychotic Episode			Recent Weight Change			Surgery:		
Mumps			Frequent Depression			Recurrent Diarrhea			Appendectomy		
Peptic Ulcer			Eating Disorder			Shortness of Breath			Tonsillectomy		
Asthma			Diabetes			Stomach Trouble			Hernia Repair		
Seizures/Blackouts			Cancer			Venereal Disease			Other Surgeries:		
Arthritis			Hearing Difficulty			Dizziness, Fainting					
Have you received treatment or counseling for an anxiety condition, personality or character disorder, or emotional problem?						Give details					

HEALTH CARE PROVIDER COMPLETES

PHYSICAL EXAMINATION
(Required for all full-time graduate students)

Temperature _____ Blood Pressure _____ Pulse _____ Height _____ Weight_____

CHECK – normal	Y	N		Y	N		Y	N	If answer is "NO" explain below
Development			Tonsils			Abdomen			
Posture			Neck			Genitalia			
Skin			Thyroid			Upper extremity			
Ears			Chest			Lower extremity			
Eyes			Heart			Bones and joints			
Nose			Lungs			Feet			
Mouth			Breasts						

Vision (without glasses) Right _____ Left _____ (with glasses) Right_____ Left_____

Routine Urinalysis _____ Albumin _____ Sugar_____ Microscopic _____

1. Current medications (please list):

_____

2. Activity limitations?

_____

3. Is patient ready to undertake college activities? ❒ Yes ❒ No If "no" please explain. _____

_____

Comments: _____

_____

_____

_____

_____

Signed: _____ _____ Date:_____
Physician Signature

Address: _____ Phone:_____