

Hellenic College 50 Goddard Avenue Brookline, MA 02445

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me:Last	First		Middle	SSN	
ress:Number a	and Street	City	State	Zip	
: F M Date of Birth	:	Marital Status:	No. of Chi	dren:	
dical Insurance Company:		Group No	Policy No.		
son to contact in case of an eme	rgency:		Phone Number:		
you a Military Veteran? 🗖 Ye	es 🗖 No Date of Discharge:		Are you a Mil	itary Dependent? 🗖 Yes 🗖	
r of Enrollment:			Attending: 🗖 Full-time 🔲	Part-time	
	ege, please give the semester and ye		-		
Tetanus-Diphtheria nmunization:	Hepatitis B	Measles (Rubeola) after 1980 1 ^a Immunization:	Mumps Immunization:	Rubella (German Measle Immunization: OR	
mmunization: Date within 10 years PD Skin Test: Anatoux Date within post 12 months Result: Negative Positive If PPD results are positive, a chest	1st Immunization: AND Date 2nd Immunization: AND Date 3rd Immunization: Date Result of Titer	Measles (Rubeola) after 1980 1st Immunization: AND Date 2st Immunization: OR after 1980 Date Date of Disease: OR Date Immune Titer: Result of Titer	Immunization: OR Date Date of Disease: OR Date Immune Titer: Result of Titer Other Immunizations Oute Other Immunizations Date Giv	Immunization: OR Date Date of Disease: OR Date Immune Titer: Date Result of Titer	
mmunization: Date within 10 years PPD Skin Test: Mantoux Date within past 12 months Result: Positive If PPD results are positive, a chest Chest X-Ray (full-sized, posteroal	1st Immunization: AND Date 2st Immunization: AND Date 3st Immunization: Date Result of Titer x-ray is required Interior) for Tuberculosis screening	Measles (Rubeola) after 1980 1st Immunization: AND Date 2st Immunization: OR after 1980 Date Date of Disease: OR Date Immune Titer: Result of Titer	Immunization:	Immunization: OR Date Date of Disease: OR Date Immune Titer: Date Result of Titer ren:	
Immunization: Date within 10 years PPD Skin Test: Montoux Date Within post 12 months Result: Positive If PPD results are positive, a chest Chest X-Ray (full-sized, posteroal	1st Immunization: AND Date 2nd Immunization: AND Date 3rd Immunization: Date Result of Titer x-ray is required	Measles (Rubeola) after 1980 1st Immunization: AND Date 2st Immunization: OR after 1980 Date Date of Disease: OR Date Immune Titer: Result of Titer	Immunization: OR Date Date of Disease: OR Date Immune Titer: Result of Titer Other Immunizations Oute Other Immunizations Date Giv	OR Date Date of Disease: OR Date Immune Titer: Result of Titer ven:	
Immunization: Date within 10 years PPD Skin Test: Montoux Date Within past 12 months Result: Negative Positive If PPD results are positive, a chest Chest X-Ray (full-sized, posteroal Date Signature, address and date of physicity immunizations. (Please place physicity TUDENT OR P R ALL STUDENTS UNDE	1st Immunization: AND Date 2st Immunization: AND Date 3st Immunization: Date Result of Titer x-ray is required Interior) for Tuberculosis screening	Measles (Rubeola) after 1980 1st Immunization:	Immunization: OR Date Date of Disease: OR Date Immune Titer: Result of Titer Other Immunizations Other Immunizations Date Give All Students Under Age mpleted primary series only: Date Give	Immunization:	

Student's Signature

Date

STUDENT COMPLETES

Last Name			First Name			Middle			SSN		
		MEDICAL				HISTORY					
HAVE YOU HAD?	γ	N	HAVE YOU HAD?	γ	N	HAVE YOU HAD?	γ	N	HAVE YOU HAD?	Υ	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 undergraduate students)

Temperature		Bl	ood Pressure		P	Pulse	Heigl	nt	Weight	
CHECK – normal	Υ	N		Υ	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)	sion (without glasses) Right				_ Left (wi			es) Righ	ntLeft	
Routine Urinalysis			Albumin			Sugar			Microscopic	
2. Activity limitations? 3. Is patient ready to undertake college activities? Yes No If "no" please explain.										
Comments:										
Signed:								 Da	te:	
ŭ <u></u>		Phys	sician Signature							
Address:	Address:							Pho	one:	