STUDENT MEDICAL RECORD

Instructions: The Office of Admissions requires each Applicant to complete a medical history form and have a physical examination done.

PART I (To be completed by applicant)

Date: ______________________________

Applicant's name: ____

Present address: ____

City: _________________________________State: ______________Zip: _____________Country: ____________

Phone: __________________________________

Gender: Male Female

Date of Birth: ______________________________ Age: ________

Parent or Guardian:

Name: ____Phone: _________________________________

Address: ____

City: ____State: ______________________Zip: _________________

Family Physician:

Name: ____Phone: _________________________________

Address: ____

City: ____State: ______________________Zip: _________________

Are you allergic to any antibiotics or other medications? Yes No

If yes, please specify:_________________

Are you presently under a medical doctor's care? Yes No

If yes, for what? ____

Are you taking prescription medicines? Yes No

If yes, explain: ____

____

(turn over)

Health records will be held in strict confidence as with all other materials submitted in application to SwCC. The applicant is to sign below that he/she has read this statement and thereby authorizes SwCC administration to release necessary health information in emergency or life-threatening situations. (If applicant is under 18 years, he/she should have his/her parents or guardian co-sign.)

_______________________________ _______________________________

Applicant Parent/Guardian

Part II: PHYSICAL EXAMINATION (To be completed by physician.)

Height: ______________ Weight: __________ Blood Pressure: ______________

Heart and Rhythm of Pulse: ________________________

Teeth: ____ Skin : __________________________________

Eyes: ____ Right 20 /____ Left 20 /____

Ears: ____ Nose: ___________________________________

Throat (Tonsils): _______________________________Sinuses: _________________________________

Lungs and Chest: ______________________________ Breasts: _________________________________

Urine (Protein): _______________________________ Sugar: __________________________________

Has student ever had a Chest X – Ray Yes No

Are there any thyroid or glandular difficulties?____

Are there any weaknesses or limitations?____

Do you consider the applicant's health adequate for intensive schoolwork and activities? Yes No

Remarks / Recommendations: ____

____

IMMUNIZATION RECORD

Vaccine	Date	Date	Date	Date
DTP				
TD or Tetanus				
Polio				
TBC Test				
Mumps				
Rubella (German Measles)				

____

Physician Signature Date

____

(Address) (City) (State) (Zip)

Please return this form at your earliest convenience to:

Southwestern Christian College

Admissions Office

P.O. Box 10

Terrell, TX 75160