MEDICAL EXAMINATION FORM

Must be completed by a licensed physician, nurse practitioner, or physician's assistant.

Demographic Information

Student's Name ____________________________________ Date of Birth __________ Gender: Male / Female
(Print) Last First Middle

Home Mailing Address ____
Number and Street or RFD

____
City State Zip Code

Student's Cell Phone ______________________ Home Phone _______________________

Name of Emergency Contact ____ Relationship________________

Address ____ Phone Number _____________________

Personal Medical History

Do you or have you ever had any of the following conditions? Please check all that apply and explain below.

1. Anemia
2. Anorexia/Bulimia
3. Anxiety
4. Asthma
5. Blind/visual impairment
6. Cancer / Malignancy
7. Celiac Disease
8. Chest Pain/Pressure
9. Cystic Fibrosis
10. Deaf/Hearing impairment
11. Depression
12. Diabetes
13. Emotional/Mental Illness
14. Heart Murmur/ Palpitations
15. Hepatitis
16. High/Low Blood Pressure
17. High Cholesterol
18. Impaired Mobility/Paralysis
19. Injury/Disease of Bones
20. Kidney Disease
21. Lupus / SLE
22. Migraines/Headac hes
23. Neuromuscular Disease
24. Phlebitis/Deep Vein Blood Clot
25. Positive TB Skin Test
26. Seizure Disorder
27. Sickle Cell Trait/Disease
28. Sinusitis
29. Strep Throat
30. Surgery
31. Thyroid Disease
32. TB Disease
33. Ulcer/Stomach
34. Unconsciousness
35. Weakness
36. Other

PLEASE EXPLAIN ALL POSITIVE ANSWERS (with dates):

____

____

List Current Medications and OTC Supplements:

____

____

Medication Allergies: Penicillin Sulfur Other _______________Type of reaction: ___________________. Severity__________________

Food Allergies: ______________________ Type of Reaction: _______________________ Severity:

____

Environment Allergies: Pollen Grass Other ____________________

Have you ever been treated with an **EPI-PEN**? YES NO Do you carry an EPI-PEN? YES NO

Explain: ____

Family History

Father: Alive / Deceased Health conditions: _________________________ If deceased, what age and cause ____________________

Mother: Alive / Deceased Health conditions: _________________________If deceased, what age and cause ____________________

Siblings: Alive / Deceased Health conditions: ________________________ If deceased, what age and cause ____________________

Siblings: Alive / Deceased Health conditions: ________________________ If deceased, what age and cause ____________________

Student's Name: ___________________________ Date of Birth: _____/___/____

Tuberculosis Test: PPD

Date Placed: ________________
Date Read: _________________
Result: Negative Positive
_______ mm induration

Urinalysis:

Glucose: ___________
Protein: ____________
Leukocytes: ________
Blood: _____________

Labs:

Hemoglobin: ___________
A1C: _______ (for DM only)

Chest Xray (if PPD Positive) Attach Xray Report

Date of Chest X-ray ____________
Result of Chest X-ray ___________
Student receiving therapy: _______
Yes No Refused

Immunization or titer dates: (***Attach Immunization Record for review***)

Tdap____________________
Td ______________________
Hep B ___________________
MMR ___________________
Varicella _________________

Covid Vaccine
Manufacturer___________
1st dose _______________
2nd dose_______________

Physical Examination		
Height: Weight: BMI:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: Y /N		
Medical	**Normal**	**Abnormal Findings**
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat Pupils equal Hearing wnl		
Lymph Nodes		
Heart Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin (Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis)		
Neurological		
Musculoskeletal	**Normal**	**Abnormal Findings**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thighs		
Knees		
Leg and ankle		
Foot and toes		
Functional (Double-leg squat test, single-leg squat test, and box drop, or step drop test.)		

****Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.**

Recommendations for physical activity/sports:

No Restrictions Not medically cleared for physical activity/sports Activity with Restriction (explain):

____

Physician or NP Signature: ____

Printed Name of health care professional: ____

State/License # ________________________________ Date of Physical Exam: ______________________

Address: ____________________________________ Date Form Signed: __________________________

Use Office Stamp:

MAIL COMPLETED FORM TO:
MORRIS COLLEGE
HEALTH SERVICES CENTER
100 West College Street
Sumter, SC 29150
Fax: 803-774-7095