WALKABOUT

CONFIDENTIAL MEDICAL HISTORY
AND PHYSICAL EXAMINATION RECORD

INSTRUCTIONS

1. Applicant completes Part 1.
2. Parent or Guardian completes and signs Part II, if applicant is under legal age. Otherwise applicant completes this.
3. IMPORTANT: Return completed form to GREENVILLE COLLEGE. Parts II and III *must* have signatures.

PART 1. A. GENERAL INFORMATION (To be completed by applicant)

1. Name____

2. Street______________________City__________State________Zip____

3. Home Telephone [1](__________)________________ 4. Today's date______________
   Area code

5. Present Age______________________ 6. Birth date______________

7. Male_______ Female_______

8. Family Physician______________

9. ______________________________ (______)______________
   Physician's Full Address — Area Code — Telephone

10. Person to be notified in case of illness or injury______________________
    Name

    ______________________________ (______)______________
    Full Address — Area Code — Home Telephone

    Business Telephone(_____)______________ Relationship______________

PART II. To be completed by Parent or Guardian, *if* Applicant is under legal age (*otherwise* Applicant should complete and sign this section).

MEDICAL INSURANCE COVERAGE

Students are covered by the insurance policy required of all undergraduate students. For those who have additional coverage through their parent's insurance or any other source must complete the following:

1. Indicate name or names of additional insurance companies you are covered by.____________________

____

2. Indicate Policy or Certificate number. ______________________________

3. Address of Insurance Company office to which we could write for forms.______________________

Consent is hereby given for the applicant to attend the WALKABOUT course. . .

Date:______________ x______________________ x______________________

Applicant's signature

Signature of Parent/Guardian (if applicant is under 18)

____

Turn in this form by July 1.

PART III. MEDICAL HISTORY

If the applicant has had any of the following conditions or is currently experiencing any of them, please put a check next to the number and give details at the end of this section.

1. Any problem with vision or hearing - require glasses or hearing aid
2. Problems with teeth - use of denture or bridge
3. Dizzy spells, fainting, convulsions, persistent headaches
4. Motion sickness
5. Frequent infection of throat, tonsils, sinuses, ear
6. Chronic cough, bronchitis, bloody sputum
7. Shortness of breath, or asthma on exertion
8. Chest pains on exertion or deep breathing
9. Palpitation of the heart, irregular heart beat, heart murmurs, or poor circulation
10. Low or high blood pressure
11. Frequent nausea or vomiting, food intolerances, heartburn
12. Jaundice or hepatitis
14. Frequent diarrhea or blood in the stools
14. Frequent abdominal cramps, severe menstrual cramps
15. Hernia
16. Difficulty urinating, burning or pain on urination, frequency in urinating, bed wetting
17. Kidney infection or stones
18. Chronic pain in neck, back, shoulders, arms or legs
19. Broken bones, joint dislocations, serious sprains, weakness of muscles
20. Joint pains, swelling or stiffness without injury
21. Any severe injury to head, chest, internal organs
22. Severe illness requiring hospitalization or prolonged incapacitation
23. Chronic skin problems (rash-infection)
24. Reaction to extremes of temperature, frostbite, impaired circulation
25. Claustrophobia, agoraphobia, acrophobia, (strong fear of confined places, open areas, or heights)
26. Continuing use of alcohol, drugs, or medicines
27. Episodes of depression, anxiety, hysteria, nervousness
28. History of diabetes, thyroid trouble, bleeding problems
29. Currently on any medication.* If so, what?
30. Special dietary restrictions. Is the applicant a vegetarian/macrobiotic?
    GREENVILLE COLLEGE cannot meet any special requirements
31. Hypoglycemia

If you checked any of the items above, please list details below according to item number. Be specific (e.g. include dates, names of medication, history of condition, etc.) Use additional paper if necessary.

Item no. ____
____
____
____
____

*If the student is receiving medication, please bring adequate amounts of the medication to the school in waterproof non-breakable containers, along with dosage instructions.

32. Is the applicant allergic to any of the following?

Medication (e.g. penicillin, aspirin, sulfa, etc.?)______________________________

Foods (e.g. shellfish, etc.?)______________________________

Insect bites (e.g., bee stings, etc.?)______________________________

Other (e.g., materials, etc.?)______________________________

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EXAMINATION (To be completed by Applicant)

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1. Applicant's Birth date____________________

2. Height__________ Weight__________ BP__________ P__________
Irregularities?
Overweight_______ Underweight______

3. General Appearance and State of Nutrition:____________________

4. GENERAL HEALTH: CHECK IF NORMAL, DESCRIBE IF ABNORMAL:

Skin:

Lymph nodes:

Eyes:

Ears:

Nose:

Mouth & Throat:

Neck:

Thorax and Lungs:

Abdomen:

Extremities:

Feet:

Knees:

Peripheral vessels:

Back:

Genitalia:

CNS:

Thyroid:

Hernia:

Scars:

Heart:

LABORATORY

Urinalysis:

Hemoglobin:

Other Lab data available:

REMARKS:____________________

____

____

____

____

5. Immunizations and Tests:

A. Has the applicant had a Tetanus Toxoid Series?__________ Date of last booster__________

B. Has the applicant been immunized against Polio? (Salk of Sabine)__________
(within 5 years)

Date of last Booster__________
(within 10 years)

C. If over 21, applicant should have had a chest x-ray within the last year.

Results:____________________

If under 21, a TB Tine Skin Test can be substituted. Results:__________

6. Is the applicant now under treatment of a psychologist or psychiatrist?__________
If yes, give his or her name:
Name:____________________ Street____________________

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City:____________________________State:____________Zip:_____________Phone(___)________________
Area code

Has the applicant attended a psychiatric clinic in the past?__________________________________

If yes, give details:____

____

7. Has the applicant had or does he/she presently have a drug-related problem?_________________
If yes, give details:____

____

8. What is the applicant's current level of physical activity?____

____

NAME of examining physician (optional): please print:____

SIGNATURE of examining physician:____

ADDRESS:____ PHONE:(________)________________________

DATE:____

PLEASE RETURN THIS COMPLETED RECORD TO GREENVILLE COLLEGE, THE ADDRESS IS LISTED BELOW:

- ***A full OBGYN exam is not required unless recommended by your physician.***

GREENVILLE COLLEGE
Office of Student Development
315 E. College Ave.
Greenville, IL 62246

Turn in this form by July 1.