Emmaus Bible College - Physical Examination Form

To be completed by healthcare provider

All full-time students at Emmaus Bible College must have a physical exam no less than 12 months prior to enrolling. This form must be submitted prior to enrollment. Student-athletes must have a physical exam each year prior to participation in athletic practices or contests and within one year of all athletic sponsored practices and contests.

Personal Data

Name: Last: First: Middle: **Birthdate:**

Height:	Weight:	Handed (Circle): Right Left	BP	Pulse

Vision: Left Eye:	Right Eye:	Both Eyes:	Glasses or contacts

Are there any abnormalities in the following systems:

	Yes	No		Yes	No		Yes	No
1. Head			9. Nervous System			e. Hand		
2. Eyes, Ears, Nose or Throat			10. Psychiatric (incl. eating disorders)			f. Back		
3. Respiratory			11. Skin			g. Hip		
4. Cardiovascular			12. Musculoskeletal			h. Thigh		
5. Gastrointestinal			a. Neck			i. Knee		
6. Hernia			b. Shoulder			j. Ankle		
7. Genitourinary			c. Elbow			k. Foot		
8. Metabolic/Endocrine			d. Wrist			l. Scoliosis		

Describe any abnormalities:

IMMUNIZATIONS AND TESTS Complete the form below, or attach a copy of the student's immunization record

VACCINE	**DOSES** (enter month, day and year each immunization was given:			**BOOSTER & DATES**	
Diphtheria and Tetanus (Circle): DTaP, ETP, DT, TD	1	2	3	4	5
Polio (Circle): OPV, IPV	1	2	3	4	5
Measles, Mumps, Rubella	1	2	3		
Hepatitis B	1	2	3		
HIB	1	2	3		
Varicella disease or vaccine	1	2	3		
Meningitis	1	2	3		
Other	1	2	3		

Do you consider the student's health adequate for intensive schoolwork (Circle)? YES NO

CLEARANCE FOR ATHLETICS: Only to be completed if student will participate in Emmaus Athletics. The physical exam date must be within one year of all athletic sponsored practices and contests.

_____ Cleared without restriction

_____ Cleared pending follow up with (Circle) Physician Orthopaedic Athletic Trainer Other _____ for _____

_____ Not Cleared for _____ Reason: _____

Signature of Examiner:		Date:	
Print Name		Are you the regular provider?	
Address: Street	City	State	Zip
Phone:			

Emmaus Bible College - Medical History

To be completed by student/applicant

Name	Date of Birth (M/D/YYYY):	Age:	Gender (circle): Male Female
Year in College (Circle): New Student Sophomore Junior Senior		Student's Cell Phone:	
Permanent Address:	City	State	Zip
Parent Name:		Parent's Cell Phone:	
Emergency Contact: (if different from above)	Name:	Relationship:	
	Street Address		
	City / State / Zip	Emergency Contact's Cell Phone:	

ALLERGIES (medication, food, pollen, stinging insects):	**CURRENT MEDICATIONS (including asthma inhalers, epi pens):**

Do you require a special diet (circle)? YES NO

If yes, explain

Yes	No	Does this student have/ever had?	Yes	No	Does this student have/ever had?
		1. Anemia?			19. High blood pressure or high cholesterol?
		2. Any illness lasting more than (1) week?			20. Head injury, concussion, unconsciousness?
		3. Asthma or difficulty breathing during exercise?			21. Headache, memory loss, or confusion with contact?
		4. Hearing loss?			22. Numbness, tingling or weakness in arms or legs with contact?
		5. Diabetes?			23. Severe muscle cramps or illness when exercising in the heat?
		6. Epilepsy or other seizures?			24. Fracture, stress fracture or dislocated joint(s)?
		7. Eyeglasses or contacts?			25. Injuries requiring medical treatment?
		8. Herpes or MRSA?			26. Knee injury or surgery?
		9. Hospitalizations (overnight or longer)?			27. Neck injury?
		10. Marfan Syndrome?			28. Orthotics, braces, protective equipment?
		11. Missing organ (eye, kidney, testicle)?			29. Other serious joint injury?
		12. Mononucleosis or Rheumatic fever?			30. Painful bulge or hernia in the groin area?
		13. Seizures or frequent headaches?			31. X-rays, MRI, CT scan, physical therapy?
		14. Surgery?			32. Anxiety / Depression?
		15. Chest pressure, pain, or tightness with exercise?			33. ADD/ADHD/learning disability?
		16. Excessive shortness of breath with exercise?			34. Eating disorder?
		17. Headaches, dizziness or fainting during, or after, exercise?			35. A doctor restricted or denied participation in sports for any reason?
		18. Heart problems (racing, skipped beats, murmur, infection, etc.)?			
Yes	**No**	**FAMILY HISTORY**			
		35. Does anyone in your family have Marfan syndrome?			
		36. Has anyone in your family died of heart problems or unexpected/unexplained reason before the age of 50?			
		37. Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?			
		38. Has anyone in your family had unexplained fainting, seizures, or near drowning?			
		39. Does anyone in your family have asthma?			
		40. Do you or someone in your family have sickle cell trait or disease?			

Use this space to explain any **"YES"** answers from above (questions 1-40) or to provide any additional information:

FOR FEMALES ONLY

1. How old were you when you had your first menstrual period? _____
2. How many periods have you had in the last 12 months? _____

Authorization for Treatment

I hereby authorize qualified personnel to give medical care while the above-mentioned student is attending Emmaus Bible College. It is understood that in the case of serious illness or accident, the family of the student will be notified. However, should it be impossible to reach the parent/guardian, and an emergency procedure is deemed necessary, it is understood, further, that the family hereby empowers the authorities of Emmaus Bible College to authorize said operation or procedure.

Applicant's Signature: _____ **Date:** _____

Parent or Guardian Signature:
(if applicant is under 18) _____ **Date:** _____