TEXAS COLLEGE
MEDICAL EXAMINATION FORM
All Information kept Confidential

Name: _____
Last First Middle
Address: _____City: _____ ST: _____ Zip: _____

Telephone: (____) _____ Date of Birth: _____Gender: M/F (Please Circle)

Name of person case of emergency: _____Relationship to you: _____
Telephone: (_____) _____

I. Record of illness: (Check those that occurred within the past five (5) years).

Frequent Colds	_____	Allergies	_____	Bone Disease	_____
Influenza	_____	Chickenpox	_____	Skin Disease	_____
Bronchitis	_____	Hernia	_____	Diabetes	_____
Pneumonia	_____	Cholera	_____	Kidney Disease	_____
Tuberculosis	_____	Rheumatic Fever	_____	Other	_____
Asthma	_____	Specify: _____			

II. Have you had any of the following to occur? (Check those that occurred within the past five (5) years).

Blurred Vision	_____	Leg Pains	_____	Vomiting	_____
Recurring Headaches	_____	Palpitation	_____	Sore Throat	_____
Blackouts	_____	Respiratory Problems	_____	Abdominal Pains	____
Fainting Spells	_____	Frequent Urination	_____	Constipation	_____
Painful Joints	_____	Problems Urinating	_____	Nosebleed	_____
Backaches	_____	Cough (prolonged)	_____	Hepatitis	_____

III. Physical Examination (<u>Must See A License Physician To Complete This Section</u>):

AREA	**COMMENTS**	**AREA**	**COMMENTS**
Skin:	_____	Lymph Glands	_____
Eyes:	_____	Chest:	_____
Nasopharynx:	_____	Lungs:	_____
Tonsils:	_____	Heart:	_____
Thyroid:	_____	Genitalia:	_____
Blood Pressure:	_____	Pulse:	_____
Urine (Albumin):	_____	Microscope:	_____
(Specific Gravity):	_____	Diabetes:	_____
Hemoglobin:	_____	Allergies:	_____

Immunization for Bacterial Meningitis: _____ **(High Importance)**

Mental or Emotional Disorders:_____

Recommendations: _____

I hereby certified that this student has been examined by me and is mentally and physically able to enroll in this school.

_____ _____ _____
Examining Physician's Signature Telephone Date

_____ _____ _____
Physical Address City/St Zip

Rev/2010