**Medical History Form**

This portion is to be completed by the student

Name

Last First Middle SS#/ID

Home Address

Street City State Zip

/ /

Cell Phone Date of Birth Male Female

Emergency Contact Phone Relationship

This medical data is necessary to serve as a baseline for medical clearance for actual enrollment. Details of abnormalities should be recorded. Please check YES or NO to the following conditions.

|  |  |  |
| --- | --- | --- |
| **CONDITIONS** | **NO** | **YES** |
| Hypertension |  |  |
| Rheumatic fever or heart trouble |  |  |
| Liver trouble or jaundice (Hepatitis) |  |  |
| Asthma or tuberculosis |  |  |
| Major surgery or injury |  |  |
| Ulcers or gastroenteritis |  |  |
| Backache or joint trouble |  |  |
| Kidney trouble |  |  |
| Diabetes |  |  |
| Severe headaches |  |  |
| Epilepsy or convulsions |  |  |
| Dyspnea |  |  |
| Drug or alcohol problem |  |  |
| Has applicant been treated for any emotional disorders? |  |  |
| Has applicant, because of his/her health, withdrawn from college? If so explain |  |  |
| Does the applicant have any illness or medical condition that requires regular treatment? |  |  |
| Does the applicant miss school regularly or frequently due to any physical condition? |  |  |
| Has the applicant been hospitalized? |  |  |
| Any family member with chronic illness, mental or nervous disorders? |  |  |
| Anemia |  |  |
| Learning disability |  |  |

Comments:

Present Health: Good Fair Poor Date of last exam: / /

Complete and return to:

This portion is to be completed by a Physician.

Height Weight Skeletal Size: Small Medium Large EL

B/P Pulse Respiration Temperature

**Laboratory Findings**

Hemoglobin or Hematocrit WBC Serology

Urine: Sp.Gr Alb Sugar

|  |
| --- |
| **Eyes** |
| Do you wear glasses? |  | No |  | Yes |
| Do you wear contacts? |  | No |  | Yes |
| Distant Vision | Without glasses | R20/ |
| With glasses | R20/ |
| Near Vision | Without glasses | R20/ |
| With glasses | R20/ |

|  |  |
| --- | --- |
| **Ears** |  |
| Hearing normal? |  | No |  | Yes |
| Are drums intact? |  | No |  | Yes |
|  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| Head, Neck and Face | Normal ( ) | Abnormal ( ) |
| Nose and Sinuses | Normal ( ) | Abnormal ( ) |
| Mouth and Throat | Normal ( ) | Abnormal ( ) |
| Teeth | Normal ( ) | Abnormal ( ) |
| Lungs and Chest | Normal ( ) | Abnormal ( ) |
| Heart | Normal ( ) | Abnormal ( ) |
| Vascular System | Normal ( ) | Abnormal ( ) |
| Abdomen | Normal ( ) | Abnormal ( ) |
| Endocrine System | Normal ( ) | Abnormal ( ) |
| Female: Breast | Normal ( ) | Abnormal ( ) |
| Female: Pelvic | Normal ( ) | Abnormal ( ) |
| Male: Genital | Normal ( ) | Abnormal ( ) |
| Male: Hernia | Normal ( ) | Abnormal ( ) |

Present Health: Good Fair Poor Date of exam: / /

I certify that the above information is true.

Physician’s Signature Student’s Signature

Complete and return to:

**TO BE COMPLETED BY COLLEGE OFFICIAL**

Date Received:

Signature:

**Immunization Form**

To ensure the health and safety of our campus, immunizations against communicable disease is extremely important. Vaccination against Measles, Mumps, Rubella (MMR), Tetanus, and Meningococcal is required, as well as a negative Tuberculosis skin test. This is a requirement for all International Students. This form must be completed and submitted prior to admission in any ACCS institution.

Name

Last First Middle SS#/ID

Address

Street City State Zip

Date of Birth / / Contact Number Email

|  |
| --- |
| **Section A: Required Immunizations/Tests** |
|  | Month/Day/Year | Month/Day/Year |
| 1. Meningitis Vaccine- within the last 5 years (Menomune, Menactra, Menveo) |  |  |
| 2. Measles, Mumps, Rubella (MMR) |  |  |
| 3. Tetanus |  |  |
|  |  |  |
| 4. Tuberculosis Screening |  |  |
| TB Skin Test by PPD | Date Placed | Date Read | MM | Neg Pos |
| Chest X-Ray (if positive PPD or lab) | Date | Result | Submit copy of chest X-ray report |

|  |
| --- |
| **Section B: Recommended Immunizations**Please attach documentation of all childhood vaccinations (copy of Blue Card) |
|  | Month/Day/Year | Month/Day/Year | Month/Day/Year | Titer Date & Result |
| TD (Tetanus/Diphtheria) |  | **Do not write here** | **Do not write here** | **Do not write here** |
| **AND/OR** Tdap (Tetanus/Diphtheria) |  | **Do not write here** | **Do not write here** | **Do not write here** |
| Polio |  | **Do not write here** | **Do not write here** |  |
| Hepatitis B |  |  |  |  |
| Varicella (Chickenpox) |  |  | **Do not write here** |  |

I certify that the above dates and vaccinations are true.

Signature of License Health Care Professional or Authorized Individual Date

Complete and return to: