REPORT OF HEALTH EVALUATION

COMPLETION OF BOTH SIDES IS REQUIRED FOR ADMISSION

Return to: ASU Health Center
P.O. Box 271
Montgomery, AL 36101

Classification for the year of 20___________
DEADLINE: June 30 for Fall Semester
October 30 for Spring Semester

( ) Freshman ( ) Sophomore ( ) Junior ( ) Senior ( ) Graduate ( ) Post Graduate

The completion of this form is one of the requirements for matriculation at the University. This form serves as a basis for making decisions regarding activities at the University in which health and physical status is a factor, and as an information bank to be utilized when you seek diagnosis and treatment at the Health Center. The University does not discriminate on the grounds of race, color, sex, religion, disability or national origin in its educational programs or activities with respect to recruitment, admissions, employment or the provision of health services.

TO BE COMPLETED BY STUDENT:

Social Security Number ________________________

Email Address: ______________________________

Full Name ____ Birthday ____________________ Sex __________
(Last) (First) (MI) (Mo) (Date) (Yr)

Home Address ____

City ____ State________ Zip ________________
Telephone Numbers: ______________________________________ Home

______________________________________ Cell

In case of medical emergency, notify: ____________________________________ Relationship __________
Name

Address ____ City _______________________ State _________
Telephone Number: __________________________________

Medical History

1. Do you have any medical problems? (such as asthma, diabetes, high blood pressure, sickle cell disease, seizures, etc.) Yes___ No ___ If yes, please explain ____
2. Have you consulted a physician or been hospitalized with the past five years? Yes ___ No ___ If yes, please explain ____
3. Please list any surgery, acute or chronic illnesses, and significant injuries which you have had including dates _______
4. Have you ever been treated for mental or emotional disorders? Yes ____ No ___ If yes, please explain ____
5. Are you taking any medications regularly at the present time, or have you taken any in the past (including allergy injections, antidepressants, contraceptives, etc.)? Yes ___ No ___ If yes, please list ________________________
6. **Are** you allergic to any medications, food or other substances? Yes ___ No ___ If so, list and describe reactions:____ ____

Office Use Only: **Hold** ____________________

Status ____________________________________ **Call Clearance** ______________

The **American College Health Association recommends all first year students living in residence halls get immunized against meningococcal disease. Meningitis disease is a disease that causes severe swelling of the brain and spinal cord.**

DATES OF IMMUNIZATIONS (Please show proof, duplicate copy)

If born after 1957, show proof of two measles vaccines-done since birth or proof of having the measles.

Measles (MMR) #1: ______________________________ Measles (MMR) # 2: __________________________

TB Skin Test (within last 12 months)

Date: __________________ Results: ______________ mm ____

Signature of Reader

If TB skin test is positive, Chest x-ray: Date: _______________ Results: _______________________________________

____

Signature

TO BE COMPLETED BY PHYSICIAN:

Blood Pressure _____________ Pulse Rate ________ Respirations ________ Height: __________

Weight: __________lbs

Systems Review	Abnormalities	Within Normal Limits
Eyes, Ears, Nose, Throat		
Cardiovascular		
Respiratory		
Gastrointestinal		
Breast		
Genitourinary		
Musculoskeletal		
Endocrine		
Integumentary		
Neuropsychiatric		
Teeth		

Is there loss of, or seriously impaired organ? Yes ___________________________________ No ___________________

Recommendation for physical activity? Limited _____________________________________ No ___________________

Do you have any recommendations regarding the care of this student? Yes __________ No ___________ If yes, explain ____

____

Is this patient now under treatment for any medical or emotional conditions? Yes ___ No ___

Remarks:

Physician Signature ____ Office stamp below:

Address ____ Date of Examination:_______________