

Medical Form



AGUSM

Name _____ DOB _____ Student ID _____

Address _____ Cell Phone _____

Email _____

Medical History to be completed by student (must be completed before physical-List positive on reverse)

	Yes	No		Yes	No
Any Past Injuries			Presently Taking Medications		
Allergies			History of Head Injury		
Asthma			Significant Past Illness		
Wears contact lens/glasses			Tuberculosis or Hepatitis (Explain if Yes)		
Past Surgical Procedures			Any Ongoing Medical Problems		
Any Hospitalizations			Seizures		
Fainting or Dizziness While Exercising			Bone/Joint Problems		

Immunization

			Titer Date	Result
Diph-Tetanus Booster (dates)				
MMR Vaccine (dates)				
Hep Vaccine (dates)				
Varicella Vaccine (dates)				
PPD (date given)		PPD (Date Read)		PPD (results)

Physical Exam

Height _____ Weight _____ Blood Pressure _____ Pulse _____

	Normal	Comment/Follow-up		Normal	Comment/Follow-up
General Condition			Gastrointestinal		
Skin			Lungs		
Ears			Genito-urinary		
Eyes			Neurological		
Nose			Musculoskeletal		
Throat			Spinal		
Mouth/Dental			Nutritional Status		
Cardiovascular			Mental Health		

I certify this student is in good health, free of contagion and able to engage in activities as a health care worker.

Additional Comments: _____

PNP Signature _____

Date _____

License No. _____

Physician Signature _____

Date _____

License No. _____