Medical Information Form

TRINITY COLLEGE OF FLORIDA

Please fill out section 1 and 2.
Section 3 must be completed by your physician.

Personal Information

ATTENDANCE (check one)
❑ Full-time
❑ Part-time

HOUSING (check one)
❑ Residence Hall
❑ Commuter

ENROLLMENT YEAR
❑ Fall _____
❑ Spring _____

Name _____ Sex: ❑ Male ❑ Female
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP

SSN# _____ E-Mail _____ Marital Status _____

Phone Number (_____) _____ - _____ Date of Birth _____

Name of Parent or Guardian _____ Phone Number (_____) _____ - _____

Address of Parent or Guardian _____

Medical History

FAMILY MEDICAL HISTORY: Have any of your relatives had any of the following diseases/disorders? If yes, please explain relationship to you.

	Yes	No	Relationship		Yes	No	Relationship
Epilepsy	❑	❑	_____	Heart Disease	❑	❑	_____
Cancer	❑	❑	_____	Mental Illness	❑	❑	_____
Diabetes	❑	❑	_____	Migraine Headaches	❑	❑	_____
Tuberculosis	❑	❑	_____				

PERSONAL MEDICAL HISTORY: Have you ever experienced any of the following? If yes, give approximate age.

	Yes	No	Age		Yes	No	Age
Mumps	❑	❑	_____	Impaired Sight	❑	❑	_____
Anemia	❑	❑	_____	Whooping Cough	❑	❑	_____
Asthma	❑	❑	_____	Rheumatic Fever	❑	❑	_____
Malaria	❑	❑	_____	Emotional Illness	❑	❑	_____
Measles	❑	❑	_____	Mononucleosis	❑	❑	_____
Diabetes	❑	❑	_____	Use of Tobacco	❑	❑	_____
Jaundice	❑	❑	_____	Use of Drugs	❑	❑	_____
Pneumonia	❑	❑	_____	Use of Alcohol	❑	❑	_____
Diphtheria	❑	❑	_____	Regular use of			
Appendicitis	❑	❑	_____	Tranquilizers	❑	❑	_____
Tonsillitis	❑	❑	_____	Regular use of			
Convulsions	❑	❑	_____	Diet Pills	❑	❑	_____
Chicken Pox	❑	❑	_____				
Tuberculosis	❑	❑	_____	List any Major Injuries: _____			
Heart Disease	❑	❑	_____				
Draining Ears	❑	❑	_____				
Scarlet Fever	❑	❑	_____				
Typhoid Fever	❑	❑	_____				

List any Allergies: _____

List any other Major Illnesses: _____

List any surgeries you have undergone in the last 5 years: _____

Physical Examination

The following sections must be completed by your physician.

PHYSICIAN: Please give the following about the applicant.

Measurements: Height_____ Weight _____

Blood Pressure: _____ / _____

Vital Signs: Pulse Rate _____ Temperature _____

CLINICAL EVALUATION: (Describe every abnormality in the space provided below.)

Head, Face, Neck	❑ Normal	❑ Abnormal	Abdomen	❑ Normal	❑ Abnormal
Thyroid	❑ Normal	❑ Abnormal	Extremities	❑ Normal	❑ Abnormal
Scalp	❑ Normal	❑ Abnormal	Skin	❑ Normal	❑ Abnormal
Eyes	❑ Normal	❑ Abnormal	Neurological	❑ Normal	❑ Abnormal
Ears	❑ Normal	❑ Abnormal	Muscular System	❑ Normal	❑ Abnormal
Nose and Sinuses	❑ Normal	❑ Abnormal	Endocrine	❑ Normal	❑ Abnormal
Mouth, Teeth, Throat	❑ Normal	❑ Abnormal	Genitalia	❑ Normal	❑ Abnormal
Chest and Lungs	❑ Normal	❑ Abnormal	Breast Exam	❑ Normal	❑ Abnormal

Explanations: _____

_____

TEST RESULTS: (Must be complete and up to date)

Results of PPD Skin Test (Day & Year) (Chest X-Ray required for positive PPD)

HCT _____ Urinalysis_____

Results: _____

IMMUNIZATION: (Each applicant must have the following immunizations up to date)

Initial MMR Date (Month & Year)_____ (A Measles Titre is required if patient has had measles)

MMR Booster Date (Month & Year)_____ Tetanus (Month & Year) _____

Poliomyelitis Sabin (Month & Year) _____

Results: _____

MISCELLANEOUS MEDICAL INFORMATION:

Are you personally acquainted with the applicant's medical history? ❑ Yes ❑ No

List any known allergies, including drug sensitivities:_____

_____

Is the applicant now receiving any medication that you advise continuing? _____

_____

Is there any reason that the applicant should be limited in a regular educational program? ❑ Yes ❑ No

Has the applicant ever been restricted in a physical program before? ❑ Yes ❑ No Why? _____

_____

Are there any additional problems which should be called to our attention? _____

_____

Females only: Are menstrual periods regular? If no, please explain: _____

Do you consider the applicant physically and emotionally capable of participating in intensive academic work plus part-time employment should that be necessary? ❑ Yes ❑ No

Name of Physician_____

PLEASE PRINT SIGNATURE

Address:_____

Phone Number (____) _____ - _____ Date of Examination _____