



**MEDICAL HISTORY AND PHYSICAL EXAMINATION RECORD FOR
TUTTLE CLINIC, NORTH GREENVILLE UNIVERSITY, TIGERVILLE, SC 29688**

Name _____ Date of birth _____ Sex _____

Home Address _____ Telephone No. _____

City _____ State _____ Zip _____

Parent or Guardian _____ Telephone No. (res.) _____

_____ Telephone No. (work) _____

Address _____

Circle year entering college: 1 2 Expected enrollment date _____

If transfer, name college last attended _____

Name of family physician _____ Telephone No. _____

Address _____

PLEASE READ CAREFULLY BEFORE COMPLETING HISTORY

IMPORTANT: Legal safeguards make it necessary for every student to have on file in the Health Services Office a record of medical history and physical examinations. The physical examination is not available through North Greenville University's Health Services. However, receipt of this form by the Health Services prior to the student's enrollment fulfills that requirement.

Get your physical, have your doctor sign this form and mail it directly to:
Tuttle Clinic / North Greenville University / Tigerville, S.C. 29688

The primary purposes of this medical record are to provide a basic point for reference in case of future illness, to locate possible medical conditions needing correction before it can interfere with your studies, and to provide the health service staff with knowledge of any necessary continuing treatments. It is also used to determine your fitness for any physical training that may be required by the University.

All information revealed will be considered confidential and will not interfere with the acceptance into the University unless such findings would endanger the other students or staff.

The history portion should be carefully and completely filled out by the applicant with the help of his or her parents. This should be done BEFORE going to your physician for completion of the physical examination section. The physical examination can be done by any licensed medical doctor, but preferably by your family physician who is more familiar with your background. He will review and help you with any problems incurred with the history position.

All listed immunizations must be completed and up to date.

Incomplete documentation of these will prevent registration.

**All falsification on the record will make the applicant liable to automatic dismissal from the University.
THIS FORM MUST BE FULLY COMPLETED AND RETURNED IN ORDER TO REGISTER!**

MEDICAL HISTORY

FAMILY	IF LIVING			IF DECEASED	
	Age	Occupation	State of Health	Age at Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

List family history of any hereditary disease such as diabetes, hypertension, heart disease, etc.: _____

PERSONAL HISTORY

PAST HISTORY

Have you EVER had:

	Yes	Age	No		Yes	Age	No
Asthma				Chicken Pox			
Diabetes				Measles (Rubeola)			
Epilepsy or other Seizure Disorder				Mumps			
Pneumonia				Rubella (German Measles)			
Recurrent Bronchitis				Infectious Mononucleosis			
Surgery				Other			

Explain "Yes" answers briefly: (Physician will explain technical details) _____

Do you have drug allergies? Yes _____ No _____ If yes, explain _____

Are you now taking any medication regularly? Yes _____ No _____ If yes, explain _____

CURRENT HISTORY

Do you have a disease, condition, or any physical handicap? Explain "Yes" answers briefly listing medications, so that the medical staff of Tuttle Clinic might better serve you. _____

Have you ever had treatment for nervous or emotional illness? _____ If so, explain _____

By whom were you treated? (Name) _____
 (Address) _____

If female, indicate menstrual history. Menses regular? _____ Painful? _____

Any medication used for cramps, regulation, etc., specified _____

 Signature of Applicant

PARENTAL PERMIT

Law requires parental permission before operative procedures on minors. No operation will be performed except in extreme emergency without parents being contacted and informed. To care for such emergencies, it is desirable that the parent sign the following form.

I hereby authorize the medical staff of Tuttle Clinic to prescribe and have performed any operation deemed an emergency on _____

Date _____ Parent's Signature _____

IMMUNIZATION RECORD

Name _____ SS # _____
PRINT (LAST) (FIRST) (MIDDLE)

Date of Birth _____ / _____ / _____

Tuttle Clinic **REQUIRES** the following immunizations upon the recommendation of the American College Health Association and South Carolina Department of Health: (Note: Physicians or clinic verification is necessary.)

ALL DATES MUST INCLUDE MONTH, DAY, AND YEAR

DPT, DT, or dT (Circle one) — Must be given within the last 9 years.

Date: Mo _____ Day _____ Yr _____

POLIO — Date series completed: Mo _____ Day _____ Yr _____

MUMPS — Date: Mo _____ Day _____ Yr _____

MEASLES (Rubeola) — **Proof of 2 doses.** 1st dose must be given after 1st birthday.

Dates: #1 Mo _____ Day _____ Yr _____

#2 Mo _____ Day _____ Yr _____

RUBELLA (German Measles) — Must be given after 1st birthday.

Date: Mo _____ Day _____ Yr _____

* TUBERCULIN skin test within the last year. Type _____ Results _____

Date: Mo _____ Day _____ Yr _____

NOTE: If skin test is positive, a chest x-ray is required within 6 months prior to registration for classes.

Date _____ Results _____ Treatment (if necessary) _____

* May omit if not at risk

MENINGITIS VACCINE recommended - Not Required _____

Physician's Signature or Clinic Stamp

LABORATORY DATA

Urinalysis: S _____ Specific Gravity _____

A _____ Microscopic _____

Hemoglobin _____ gm.

PHYSICAL EXAMINATION

Weight _____ Height _____ Blood Pressure _____ Pulse _____

Visual Acuity: (Snellen) Uncorrected _____ Corrected _____

1. Corrective lens: Yes _____ No _____

2. Glasses? Yes _____ No _____

PHYSICIAN'S EVALUATION

I. HISTORY

Have you treated the applicant for any significant disease or medical problem other than minor short term illnesses?

Yes _____ No _____

If yes, please list problem with any suggestions regarding follow-up care and treatment while the applicant is under our supervision: _____

Please list any previous or existing illnesses and treatment. Attach copy(s) of evaluation. _____

II. PHYSICAL EXAM

A. Normal in every respect _____

B. Abnormalities _____

If so, please explain:

PHYSICIAN'S RATING

Do you consider this student physically and emotionally capable of doing satisfactory college work? Yes _____

No _____ Doubtful _____ Give reasons if no or doubtful _____

In your opinion is he or she physically qualified for: Unrestricted athletics or exercise _____

Restricted athletics or exercise _____ Basis for restriction _____

What level of restriction? _____

Is restriction permanent? (yes or no) _____ Temporary? (yes or no) _____ How long? _____

Special diet or other dietary considerations? Explain _____

Date of Examination _____

Signature of Examining Physician _____, M.D.

Typed or Printed Name of Physician _____

Address of Physician: (street) _____

(city) _____ (state) _____

Telephone _____ (_____) _____