CSU IMM BAND STUDENT HEALTH RECORD
PART 1—TO BE FILLED OUT BY THE STUDENT

Name ________________________ SS# ________________ DOB _____

Sex ( ) F ( ) M Contact Phone # _____________ Cellular # ______________

Present Address ____

Permanent Address ____

Medical History

1. Are there any restrictions to physical activity, please explain________________
____

2. Have you been treated by a physician or nurse practitioner in the past 5 yrs_____

For what reason ?____

3. Have you ever been hospitalized ?_________ If so, why? ________________

4. Do you have Medical Insurance ?______ Company and policy #____________________________

5. Are you allergic to any medications or latex? ___________________________

6. Give month and year of last vaccinations/inoculations:

MMR ______ Tetanus or Td _______ PPD _______Results: ( ) Neg. ( ) Pos.

Check all the following which apply to you and close relatives (parents, siblings, 1st grandparents)
Please indicate who:

You	Relative	You	Relative
( ) Allergies	( ) ____________	( ) Headaches	( ) ____________
( ) Anemia	( ) ____________	( ) Hepatitis	( ) ____________
( ) Asthma	( ) ____________	( ) Hypertension	( ) ____________
( ) Cancer	( ) ____________	( ) High Cholesterol	( ) ____________
( ) Cardiovascular	( ) ____________	( ) Stomach/Bowel	( ) ____________
( ) Diabetes	( ) ____________	( ) Kidney Disease	( ) ____________
( ) Drug & Alcohol	( ) ____________	( ) Skin Disease	( ) ____________
( ) Mental Problems	( ) ____________	( ) Thyroid Disease	( ) ____________
( ) Gallbladder/Liver	( ) ____________	( ) Tuberculosis	( ) ____________

( ) Other, please explain: ____

I certify to the best of my knowledge that the above information is complete and correct.
Applicant's Signature __________________________ Date ___________________

AUTHORIZATION FOR MEDICAL, DENTAL, SURGICAL, OR OTHER TREATMENT
I hereby authorize and consent to deemed necessary or advisable services, including but not limited to diagnostic procedures, radiology, laboratory, anesthesia, medical, surgical, dental, and or hospital services.

Signature ____________________________ Date ________________________

PART 2—TO BE COMPLETED BY A PHYSICIAN OR NURSE PRACTITIONER

Weight ___________ Height ___________ BP ______________ Pulse ____________

Vision: ______________ Test----Urinalysis: Albumin ________ Glucose___________

Serum: Hemoglobin ________ HCT ____________

Is the applicant currently receiving treatment? ______ If so, why? _________________________

CLINICAL EVALUATION

Check each item in the appropriate column	Normal	Abnormal	If Abnormal, Describe
1. Skull, Scalp, Face, Neck, Thyroid	( )	( )	___________________________
2. Skin, Lymphatic	( )	( )	___________________________
3. Ears, Nose, Throat	( )	( )	___________________________
4. Eyes	( )	( )	___________________________
5. Neurological	( )	( )	___________________________
6. Lungs and Chest	( )	( )	___________________________
7. Heart	( )	( )	___________________________
8. Abdomen	( )	( )	___________________________
9. Perineum, rectum, hernias	( )	( )	___________________________
10. Endocrine	( )	( )	___________________________
11. Musculoskeletal	( )	( )	___________________________
12. Psychiatric	( )	( )	___________________________

Please indicate whether this patient has any medical condition which would interfere with regular physical activity ____
____
____

Signature of Provider Performing Examination____________________________ Date ______________________

Provider's Printed Name, Address, and Telephone Number of Provider________________________________

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PLEASE RETURN TO:

CENTRAL STATE UNIVERSITY BANDS
P.O. BOX 1004
WILBERFORCE, OHIO 45384-1004
TEL # (937) 376-6405
FAX # (937) 376-6415
THANK YOU