

MEDICAL FORM

Please complete both sides **no later than August 1** and return to:

Florida Southern College
 Student Health Center
 111 Lake Hollingsworth Dr.
 Lakeland, FL 33801-5698

Please print in ink or type

1. Name (Last)	(First)	(Middle)	2. Date of Birth	3. Sex	4. Phone
5. Home Address	(Street)	(City)	(State)	(Zip)	6. Student Cell Phone

7. Social Security Number	8. Entrance Date	9. I authorize medical treatment for myself by the Health Services of FSC. (If student is under the age of 18, parental permission is given for medical treatment.) Parent/Student Signature: _____
10. Name of Parent or Guardian (please print)		

11. Give Dates **IMMUNIZATION RECORD - Required**

German Measles (Rubella)	Measles (Rubeola)	DPT	Mumps	Polio	Last Tetanus Booster
Required For Resident Students and Suggested For Commuting Students					
Hepatitis B #1	#2	#3	Meningitis	Other	

12. Medical History (note in detail any significant history) Use reverse side if needed.

13. Blood Pressure	14. Pulse	15. Height	16. Weight	17. Drug Sensitivity
--------------------	-----------	------------	------------	----------------------

18. Clinical Evaluation (check each item in the appropriate column) N = normal A = abnormal

	N	A		N	A		N	A
1. Nutritional	<input type="checkbox"/>	<input type="checkbox"/>	8. Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>	15. Neurologic	<input type="checkbox"/>	<input type="checkbox"/>
2. Skin/Nails	<input type="checkbox"/>	<input type="checkbox"/>	9. Heart	<input type="checkbox"/>	<input type="checkbox"/>	16. Spine	<input type="checkbox"/>	<input type="checkbox"/>
3. Head/Face	<input type="checkbox"/>	<input type="checkbox"/>	10. Lungs	<input type="checkbox"/>	<input type="checkbox"/>	17. Upper Extremities	<input type="checkbox"/>	<input type="checkbox"/>
4. Eyes/Vision	<input type="checkbox"/>	<input type="checkbox"/>	11. Breasts	<input type="checkbox"/>	<input type="checkbox"/>	18. Lower Extremities	<input type="checkbox"/>	<input type="checkbox"/>
5. Ears/Hearing	<input type="checkbox"/>	<input type="checkbox"/>	12. Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	19. Geritourinary	<input type="checkbox"/>	<input type="checkbox"/>
6. Nose/Sinuses	<input type="checkbox"/>	<input type="checkbox"/>	13. Vascular System	<input type="checkbox"/>	<input type="checkbox"/>	20. Rectum	<input type="checkbox"/>	<input type="checkbox"/>
7. Mouth/Throat	<input type="checkbox"/>	<input type="checkbox"/>	14. Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	21. Psychological	<input type="checkbox"/>	<input type="checkbox"/>

19. Describe every abnormality in detail (use reverse side if necessary).

20. Describe any current treatment - please include all medications

21. Physical Restrictions or Limitations

Date	Printed Name of Physician		Signature	
Phone	Address	(Street)	(City)	(State) (Zip)

MEDICAL HISTORY FORM

Please complete **no later than August 1** and return to: Florida Southern College
 Student Health Center
 111 Lake Hollingsworth Dr.
 Lakeland, FL 33801-5698

Name		SS#		Date / /	
Birth Date / /	Sex M F	Height	Wt.	Marital Status S M D W	
Local Address			Phone ()		
Permanent Address			Phone ()		
To be completed by student		PAST MEDICAL HISTORY		Please print in ink or type.	
	Mark "X" if you have had	Date		Mark "X" if you have had	Date
Alcohol/drug dependence			Heart problems		
Allergy/hay fever			Hemorrhoids		
Anemia/blood disease			Hepatitis		
Anxiety			High Blood Pressure		
Arthritis/joint pain			High cholesterol		
Asthma			Hypoglycemia		
Back problem			Insomnia		
Bladder/kidney			Liver disease/jaundice		
Blood in stool			Malaria		
Cancer/cyst/tumor			Mononucleosis		
Clot in veins			Pregnancy		
Constipation			Psychological problem		
Depression			Respiratory problem		
Diabetes (sugar)			Rheumatic fever		
Diarrhea			Sexually transmitted disease		
Dizziness/fainting			Shortness of breath		
Ear & nose problem			Skin problem		
Epilepsy/seizures			Strep throat		
Eye problem			Swollen glands		
Gallbladder/intestinal			Swollen joints		
Head injury			Thyroid disease		
Surgeries/hospitalization/injuries, list below:			Tuberculosis		
			Ulcer		
			Varicose veins		
			Weight problem		
			Other:		
Do you smoke?		Yes No			
How much per day?					
Do you drink alcohol or use marijuana?		Yes No	Do you have any allergies to medication? Yes No		
How much per day?			If yes, please list:		
Current medications:					
			Do you have any other allergies?		Yes No
			If yes, please list:		