ST. MARY'S COLLEGE
200 East Mission Street
Saint Marys, Kansas 66536
(785) 437-2471

Rev. Fr. Patrick Rutledge, President
Dr. Joseph Strong, Academic Dean

MEDICAL FORM

_____ _____ _____

Student's Last Name First Name Middle

Sex _____ Date of Birth (mm/dd/yyyy) _____ SSN _____

Address _____

_____

City _____ State _____ Zip Code _____ Country _____

Phone: (____) _____ (____) _____ E-mail _____

Parent/Legal guardian _____

Address (*if different than above*) _____

_____

City _____ State _____ Zip Code _____ Country _____

Phone: (*home*) (____) _____ (*cell*) (____) _____ (*work*) (____) _____

Health History

Does this student:	No	Yes	(if yes, please explain)
1) See a physician regularly for illness or health problems?	____	____	_____
2) Have a history of hospitalization?	____	____	_____
3) Have a history of childhood diseases?	____	____	_____
4) Take medication on a regular basis?	____	____	_____
5) Have vision, speech, or hearing problems?	____	____	_____
6) Have a history of mental illness?	____	____	_____
7) Have a history of emotional problems?	____	____	_____
8) Require any special assistance in school?	____	____	_____
9) Suffer from any chronic illness or condition?	____	____	_____
10) Have any allergies, including those to certain foods?	____	____	_____

11) Have an immunization record? No____ Yes: DTP and/or TD (0 1 2 3 4 5); Oral Polio (0 1 2 3 4 5)
MMR (0 1); Other/additional explanation _____

12) Please provide any additional health information or explanation: _____

_____

Physical Examination Form

Name_____DOB_____

Height_____Weight_____Pulse _____BP _____/_____ Vision: R 20/_____ L 20/ _____ Corrected (Y/N)

	Normal	***Abnormal Findings***
MEDICAL		
Appearance		
EENT		
Hearing		
Lymph nodes		
Heart		
Murmurs		
Pulses		
Lungs		
Abdomen		
GU (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder / arm		
Elbow / forearm		
Wrist/ hand /fingers		
Hip / thigh		
Knee		
Leg / ankle		
Foot / toes		

Notes: _____

_____

_____

Name of Physician (print/type) _____Date_____

Address_____Phone_____

Signature of Physician_____, MD / DO