

# John A. Gupton College

## Student Health Form

### I. GENERAL INFORMATION

Name \_\_\_\_\_

Home Address \_\_\_\_\_

Street or Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Home Phone \_\_\_\_\_ Social Security Number \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Date of Birth \_\_\_\_\_ Citizenship \_\_\_ USA \_\_\_ other (specify) \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Hair Color \_\_\_\_\_ Eye Color \_\_\_\_\_

In case of emergency, notify \_\_\_\_\_

Relationship \_\_\_\_\_ Name \_\_\_\_\_  
Phone Number \_\_\_\_\_

### II. HEALTH CARE PROVIDER INFORMATION (REQUIRED)

<p><u>Fill out this section if born <b>AFTER 1957</b></u></p> <p>1. TB Skin test or chest x-ray (Must be within last year) Date Given: _____ Results: _____</p> <p>2. 1<sup>st</sup> dose Rubeola, Rubella, Mumps vaccination Date MMR Given: _____</p> <p>3. 2<sup>nd</sup> dose Rubeola, Rubella, Mumps vaccination Date MMR Given: _____</p> <p>_____ (Health care provider's signature or stamp)</p>	<p><u>Fill out this section if born <b>IN OR BEFORE 1957</b></u></p> <p>1. TB skin test or chest x-ray (Must be within last year) Date Given: _____ Results: _____</p> <p>_____ (Health care provider's signature or stamp)</p>
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### IMMUNIZATIONS ADVISED BUT NOT REQUIRED

Tetanus or TD \_\_\_\_\_ (Must be within last 10 years)

Hepatitis B Series: 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_

### III. PHYSICAL FINDINGS/PROBLEMS WHICH REQUIRE ONGOING CARE

____ Allergy	____ Dermatology	____ Hearing/Sight	____ Anorexia/Bulimia
____ Anemia	____ Seizure Disorder	____ Obesity	____ Blood Pressure
____ Cardiac/Heart	____ Gastrointestinal	____ Orthopedic	____ Genito Urinary
____ Depression	____ Pulmonary	____ Immune Disorders	____ Headaches/Migraine
____ Diabetes	____ Mental Illness	____ Cholesterol	____ Other _____

### IV. REQUIRED MEDICATION/PHYSICAL LIMITATIONS/ SPECIAL NEEDS

\_\_\_\_\_  
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