

Both sides of this form must be filled out completely before the applicant may register for classes. Early submission of this form will simplify the registration procedure.

MEDICAL HISTORY: The student completes this form. Please Print.

Name _____ Social Security No. _____
Last First Middle

Address _____
Number and Street City, State and Zip Code

Date of Birth _____ Age _____ Sex _____ Marital Status _____ Home Phone (____) _____

Parent's Name _____ Parent's Address _____
Number and Street City, State and Zip Code

Father's Work Phone (____) _____ Mother's Work Phone (____) _____

<p>Medical Insurance: Leave blank if not covered. Company _____</p> <p>Address _____ <small>Number and Street</small></p> <p>_____ <small>City State Zip Code</small></p> <p>Policy Number _____ Group No. _____</p>	<p>Emergency Notification: Person to notify if parents cannot be contacted Name _____</p> <p>Address _____ <small>Number and Street</small></p> <p>_____ <small>City State Zip Code</small></p> <p>Relationship _____ Hm Phone (____) _____ Wk Phone (____) _____</p>
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FAMILY HISTORY: Fill in as indicated.

Is your father living? _____ Occupation _____ Cause of death if deceased _____

Is your mother living? _____ Occupation _____ Cause of death if deceased _____

Has any member of your family suffered from: _____ Heart Disease _____ Cancer _____ Diabetes _____ Tuberculosis

If yes, give relationship _____

PERSONAL HISTORY: Circle any of the following you have had. On a separate piece of paper list details including, date, duration, and effects of any items circled.

Arthritis/Rheumatism Back Impairment Brain/Spine Diseases Carpal Tunnel Syndrome Deformities/Amputations Depression/OCR/Anxiety Diabetes Epilepsy Eye/Ear Diseases	Heart Conditions/Diseases Hepatitis Immuno-suppressed Conditions Intestine/Stomach Diseases Kidney Infection/Diseases Liver/Gall Bladder Diseases Low/High Blood Pressure Lung Diseases (Asthma, etc.) Malaria	Meningitis Menstrual Difficulties Monucleosis Paralysis Pleurisy Pneumonia Pregnancy Rheumatic Fever Scarlet Fever	Skin Diseases Speech Impairment Sexual Organs Diseases Tuberculosis Typhoid Fever Ulcers Urinary Infections/Diseases Whooping Cough Other Not Listed
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Have you ever been hospitalized? Yes No When? _____ For What? _____

Have you ever had a nervous breakdown? Yes No When? _____

Have you ever been treated by a psychiatrist for any reason? Yes No Date of treatment. _____

Name and Address of psychiatrist _____

Do you have any chronic illness? Yes No Explain _____

Are you taking any medication (insulin, Dilantin, allergy injections, special diet, etc.)? Yes No If yes, give complete information _____

Are you allergic to any foods, drugs, medicines, serum, etc.? Yes No Explain _____

Describe any exercise or physical limitation. _____

I certify that the above information is correct to the best of my knowledge. I understand that falsification of the information may result in my dismissal from the College.

Date _____ Signature of Applicant _____

Student's Printed Name _____

Required Immunizations:

Individuals 17 years of age and younger		Individuals born in 1957 or later and who are 18 years of age or older:		Individuals born prior to 1957:	
3 doses	DTP (Diphtheria, Tetanus, Pertussis) or TD (Tetanus, Diphtheria). One TO dose must have been within the last 10 years.	3 doses	DTP (Diphtheria, Tetanus, Pertussis) or TO (Tetanus, Diphtheria). One TD dose must have been within the last 10 years.	3 doses	DTP (Diphtheria, Tetanus, Pertussis) or TD (Tetanus, Diphtheria). One TD dose must have been within the last 10 years.
3 doses	POLIO (oral).	1 dose	MEASLES (Rubeola), on or after the first birthday. * ,	1 dose	Rubella .*, ***
1 dose	MEASLES (Rubeola), on or after the first birthday.	1 dose	Rubella **		

- A history of physician-diagnosed measles disease is acceptable.
- ** A history of physician-diagnosed rubella disease is not acceptable. Only laboratory proof of immunity to rubella is acceptable.
- *** Rubella dose is not required for students 50 years of age or older.

Immunization record: The student or family doctor completes this form.

IMMUNIZATION	DATE	DATE	DATE	DATE	DATE	DATE
Diphtheria						
Poliomyelitis						
Tetanus Toxoid						
Typhoid						
Measles (Rubella)						
German Measles (Rubella)						
Mumps						

Physician's Printed Name _____ Signature _____

Address _____
Number and Street City State Zip Code

Date _____ Office Phone (_____) _____ Emergency Phone (_____) _____

If your doctor does not have your immunization records, but you do have the copy from which the above information was taken, please sign below.

I certify that the above information is correct to the best of my knowledge. I understand that falsification of this Information may result in my dismissal from the College.

Date _____ Signature of Applicant _____