## BARBER-SCOTIA COLLEGE STUDENT HEALTH SERVICES

## To the Student and Parents:

This form MUST be completed for clearance in Health Service. Information you provide will be used as an aid to provide health care, if necessary, while the student is enrolled. This information is strictly confidential and will not be released without the knowledge and written consent of the student, or parent of minor or dependent student.

Part I: PERSONAL DATA	•						
Name				Social Security #//			
(Last)	(First)	(Middle)					
Home Address				Apt#			
	(Number and S						
(City)	(Sta	te)	(Zip)	_			
Emergency Contact		Relationship	0	Telephone ( )			
PART II: AUTHORIZATI	ON AND CONSE	<u>NT</u>					
				nedically necessary by ambulance in case of sted to other physicians to assist in			
Signature of Stude	ent		Parent/Guardian if minor				
PART III: HEALTH HIST Check if you have had any of		comment:					
	YES	S NO	COMMI	ENT			
HEART DISEASE							
CANCER							
HIGH BLOOD PRESSURE SEIZURES							
BROKEN BONES	-			<del></del>			
TUBERCULOSIS				<del></del>			
ASTHMA/BRONCHITIS							
MIGRANE HEADACHES							
SORE THROATS							
DIABETES							
SICKLE CELL/TRAIT				<del></del>			
HAY FEVER	-						
FREQUENT COLDS							
IRREGULAR PERIODS							
EMOTIONAL PROBLEMS							
HERNIA							
HIV/AIDS							

## PART IV: PHYSICAL EXAMINATION

Telephone ( ) \_\_\_\_\_

This form MUST be	e completed, signed and	dated by a PHYS	SICIA	N for cle	arance in F	Health Servi	ices.	
Patient's Name				OB			Age	
Height	Weight	TPR	/_	/_	BP	/		
EARS, NOSE OR TEYES (Wear Glasse RESPIRATORYCARDIOVASCUL, MUSCULOSKELE GASTROINTESTIINEUROPSYCHIAT	ities of the following sy THROAT					Yes	No	
Is there loss or impa Does patient take m Any allergies to med Any limitations for	nired function of any org edication on a daily bas dications? physical activity (PE, in	gan or limb? iis? ntramurals or Athl	letics)?		ГЕ ВҮ РН	YSICAN O	OR IMMUNICA	TION CLINIC.
	Law requires all studentese requirements cannot							
Tetanus (required w	rithin 10 years) Date				_ MMR (B	Booster) Dat	te	
Chest X-Ray if skin	t (required for admissio test is positive. Date_			Res	ults			
	commendations regardi							
Are there any physic	cal or emotional restrict	ions for this stude	ent?					_
Physician's Signatur	re			Date	e			
Print Name					_			
Address								

Complete and mail to: Barber-Scotia College Student Health Services 145 Cabarrus Avenue, West Concord, North Carolina 28025