

# Confidential Medical Exam

All applicants for admission to McKendree University are required to have the following information completed before initial course registration.

**To be completed by the student:**

Last Name : \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Date of Birth (Month/Date/Year): \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

Mailing Address (If different from above): \_\_\_\_\_

History: Have you had or are you subject to any of the following? Please give dates.

- |   |                        |                         |                          |
|---|------------------------|-------------------------|--------------------------|
| _____ Appendicitis                          | _____ Pelvic Disorders | _____ Kidney Troubles   | _____ Asthma             |
| _____ Chickenpox                            | _____ Diabetes         | _____ Hernia            | _____ Poliomyelitis      |
| _____ Tonsillitis                           | _____ Hay Fever        | _____ Scarlet Fever     | _____ Pleurisy           |
| _____ Typhoid Fever                         | _____ Pneumonia        | _____ Skin Disease      | _____ Malaria            |
| _____ Measles                               | _____ Epilepsy         | _____ Rheumatic Fever   | _____ Abdominal Pain     |
| _____ Mental Illness                        | _____ Heart Trouble    | _____ Tuberculosis      | _____ Emotional Problems |
| _____ Shortness of Breath                   | _____ Moody            | _____ Headaches         | _____ Defective Vision   |
| _____ High Blood Pressure                   | _____ Cough            | _____ Whooping Cough    | _____ Mononucleosis      |
| _____ Joint Pains                           | _____ German Measles   | _____ Sinus Infection   | _____ Joint Pains        |
| _____ Diphtheria                            | _____ Mumps            | _____ Defective Hearing | _____ Jaundice           |
| _____ Family History of High Blood Pressure |                        |                         |                          |

Injuries: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

Operations: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

Who to notify in case of serious illness or accident:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Business: \_\_\_\_\_ Residence: \_\_\_\_\_

Information in this medical report may be used to plan health care, adjudicate claims, provide classification for physical activities, and control communicable disease. In order for health care to be provided, the above named persons (or a substitute) may be given information judged necessary by an authority representing McKendree University.

Signature of Student: \_\_\_\_\_ Date: \_\_\_\_\_

Name and address of family insurance company:

Name of company: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy Number of Insurance Company: \_\_\_\_\_

SS # of Student: \_\_\_\_\_

**To be completed by the physician:**

**Laboratory Work: (At the discretion of the physician)**

Blood Analysis: Date: \_\_\_\_\_ Hemoglobin: \_\_\_\_\_ Hematocrit: \_\_\_\_\_

Urinalysis: Date: \_\_\_\_\_ Specific Gravity: \_\_\_\_\_ Albumin: \_\_\_\_\_

Sugar: \_\_\_\_\_ Blood: \_\_\_\_\_ Micro: \_\_\_\_\_

Tuberculin Test: Date: \_\_\_\_\_ Results: \_\_\_\_\_

If positive, chest X-ray required: Date: \_\_\_\_\_ Results: \_\_\_\_\_

**General Health:**

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Age: \_\_\_\_\_ Blood pressure: Sys. \_\_\_\_\_ Dis. \_\_\_\_\_

Eyes: Right: \_\_\_\_\_ Left: \_\_\_\_\_

Ears: \_\_\_\_\_ Nose: \_\_\_\_\_ Throat: \_\_\_\_\_ Heart: \_\_\_\_\_

Pulse Rate Resting: \_\_\_\_\_ Immediately after Exercise (15 hops): \_\_\_\_\_ 2 min. after \_\_\_\_\_

Lungs: \_\_\_\_\_

Hernia: \_\_\_\_\_ Neurological: \_\_\_\_\_

Do you know of any physical disability which would make it unwise for the applicant to engage in physical activities? Explain. \_\_\_\_\_

\_\_\_\_\_

Are any medicines or injections to be avoided? \_\_\_\_\_

Is the student on any maintenance medication and for what condition?

\_\_\_\_\_

Please add any further notes about the student's health which you think might be of value to the College authorities in planning the student's program.

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Classification for physical activities: *Please check one:*

Unlimited participation       Limited Participation       No participation

If limited or no participation indicated, please explain why. *This is important.*

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Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Physician (Please print): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Illinois Department of Public Health

### Immunization Requirements for Institutions of Higher Education in Illinois

**To be completed and returned prior to registration by those students who are enrolling for the first time on or after July 1, 1989.**

#### **Part I. To be completed by student: (Please print or type)**

Please fill in information requested below and give this form to your physician or health care provider for completion. Part II must be completed and signed by a physician or health care provider.

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address (If different from above): \_\_\_\_\_

Educational Institution: \_\_\_\_\_ Term for which you are enrolling: \_\_\_\_\_

#### **Part II. To be completed and signed by a physician or health care provider. (All dates must include month, day and year.)**

A. **Measles, Mumps, and Rubella:** It is *mandatory* for incoming new students born on or after January 1, 1957, to document immunity to measles, mumps, and rubella prior to enrollment. Two doses of live measles vaccine on or after first birthday, at least one month apart, or evidence of measles immunity (i.e.

prior physician diagnosed measles disease or laboratory evidence of immunity). If second dose is necessary it must be given as a M.M.R. (Measles, Mumps, Rubella).

1. *Measles (Rubella, Old Fashioned, Ten Day):*

Disease diagnosed by (Physician's signature): \_\_\_\_\_ Date: \_\_\_\_\_

Measles vaccine date: \_\_\_\_\_ Laboratory evidence of immunity date: \_\_\_\_\_

Results (Attach copy of lab report): \_\_\_\_\_

2. *Mumps:*

Disease diagnosed by (Physician's signature): \_\_\_\_\_ Date: \_\_\_\_\_

Mumps vaccine date: \_\_\_\_\_

3. *Rubella:*

Rubella vaccine date: \_\_\_\_\_ Laboratory evidence of immunity date: \_\_\_\_\_

Results (Attach copy of lab report): \_\_\_\_\_

\*History of disease is **not** acceptable as proof of immunity for rubella.

B. Tetanus/Diphtheria: It is mandatory for incoming new students born on or after January 1, 1957, to document immunity to tetanus and diphtheria prior to enrollment.

Dates of original series of DTP, DT, and/or Td:

1. (Month/Day/Year) \_\_\_\_\_

2. (Month/Day/Year) \_\_\_\_\_

3. (Month/Day/Year) \_\_\_\_\_

Most recent booster: \_\_\_\_\_ (Td booster must have been within the past 10 years.)

Signature of Physician/Health Care Provider (Person verifying that immunizations were given):

\_\_\_\_\_ Date: \_\_\_\_\_

Physician's/ Health Care Provider's Name (Please Print): \_\_\_\_\_

Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_