

MIAMI BAPTIST COLLEGE

19301 SW 127TH AVE.
MIAMI, FLORIDA 33177
(305) 238-7332

Student Health Form

Instructions to Prospective Student

1. Complete Section A Below.
2. Give this Health Form to your physician with a stamped envelope, addressed to the attention of the Registrar. Ask them to complete Section B and mail it in right away. Be sure to thank them for doing so.

All students must have a health history and physical on file. All information will be kept confidential.

SECTION A

Student Name: _____ D.O.B. _____ SEX: M F

Address: _____

City _____ State _____ Zip _____

Telephone: () _____

Personal Physician:

Telephone: () _____

Notify in case of emergency

Name: _____

Work Phone: () _____

Home Phone: () _____

If you are under 18 years of age or younger and unmarried, have a parent or guardian sign below.

"In the event of an emergency, I give my permission for my son / daughter to receive necessary medical treatment and I will be responsible for any financial debt accrued because of treatment."

Date: ____/____/____ Parent or Guardian Signature _____

CHECK any of the following which you have had or presently have: Give dates and any appropriate details.

- | | | |
|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Headaches (Migraine) |
| <input type="checkbox"/> Asthma – Respiratory ailments | <input type="checkbox"/> Drug Allergies | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Typhoid / Malaria |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Emotional Nervous Disorders | <input type="checkbox"/> Tuberculosis |
-

SECTION B: PHYSICIAN TO COMPLETE THE FOLLOWING

Rheumatic fever or rheumatism Diabetes Emotional or Nervous Disorders

Operations? _____

Familial Diseases? _____

Examinations: (General Appearance)

Vision? _____ Uncorrected: R: _____ L: _____
Corrected: R: _____ L: _____

Auditory Acuity? _____ R: _____ L: _____

Nose? _____ Throat? _____ Tonsils? _____ Teeth? _____

Chest and Lungs: (A current or recent report of chest X-ray or tuberculin skin test is required.)

_____ PPD: Date _____ Results: _____

Cardiovascular: Pulse _____ Rhythm: _____ Blood Pressure: _____

Heart: Murmurs? _____ Blood Disorders: _____

Abdomen and Genitalia: Hernia? _____ Other? _____

Nervous System and Reflexes: _____

Routine Urinalysis: Sp. Gr.: _____ Albumin: _____ Sugar: _____

Immunization Vaccinations: Are immunizations up to date? YES NO

Any known allergies to medications, food, etc.: _____

Is this student presently taking any medications routinely? (specify drug, dosage and why medications is being taken)

How long have you known/treated this student? _____

Summary of General Condition: (Please include limitations of physical activities and reasons for such.)

Doctor's Name: _____ Phone () _____

Address: _____

Doctor's Signature: _____ Date Signed: _____