JOHN A. GUPTON STUDENT HEALTH FORM

I. GENERAL INFORMATION

NAME:

_____
(LAST) (MI) (FIRST)

HOME ADDRESS:

_____
(STREET OR BOX) (CITY) (STATE) (ZIP CODE)

HOME PHONE: (__ __ __) - __ __ __ - __ __ __ __ **CELL PHONE:** (__ __ __) - __ __ __ - __ __ __ __

SOCIAL SECURITY NUMBER: __ __ __ - __ __ - __ __ __ __ **MALE:** ❑ **FEMALE:** ❑

DATE OF BIRTH: __ __ / __ __ / __ __ __ __ (MONTH) (DAY) (YEAR) **CITIZENSHIP:** _____ **USA:** _____ **OTHER:** _____ (SPECIFY)

HEIGHT: _____ **WEIGHT:** __ __ __ **LBS. HAIR COLOR:** _____ **EYE COLOR:** _____

IN CASE OF EMERGENCY, PLEASE NOTIFY: _____

RELATIONSHIP: _____ **PHONE NUMBER:** (__ __ __) - __ __ __ - __ __ __ __

II. HEALTH CARE PROVIDER INFORMATION *(REQUIRED)*

IF YOU WERE BORN AFTER 1957 PLEASE FILL OUT THIS SECTION:

1.) **TB SKIN TEST OR CHEST X-RAY:**
(MUST BE WITHIN LAST YEAR)
DATE GIVEN: __ __ (MONTH) / __ __ (DAY) / __ __ __ __ (YEAR)
RESULTS: _____

2.) **1ST DOSE RUBEOLA, RUBELLA, MUMPS VACCINATION:**
DATE MMR GIVEN: __ __ (MONTH) / __ __ (DAY) / __ __ __ __ (YEAR)

3.) **2ND DOSE RUBEOLA, RUBELLA, MUMPS VACCINATION:**
DATE MMR GIVEN: __ __ (MONTH) / __ __ (DAY) / __ __ __ __ (YEAR)

HEALTH CARE PROVIDER'S SIGNATURE OR STAMP:

_____

IF YOU WERE BORN IN OR BEFORE 1957 PLEASE FILL OUT THIS SECTION:

1.) **TB SKIN TEST OR CHEST X-RAY:**
(MUST BE WITHIN LAST YEAR)
DATE GIVEN: __ __ (MONTH) / __ __ (DAY) / __ __ __ __ (YEAR)
RESULTS: _____

HEALTH CARE PROVIDER'S SIGNATURE OR STAMP:

_____

IMMUNIZATIONS *(ADVISED BUT NOT REQUIRED)*

TETANUS (OR) TD: _____ **(MUST BE WITHIN THE LAST 10 YEARS)**

HEPATITIS B SERIES: 1ST _____ **2ND** _____ **3RD** _____

III. PHYSICAL FINDINGS *(PROBLEMS WHICH REQUIRE ON-GOING CARE)*

- ❑ ALLERGY
- ❑ ANEMIA
- ❑ CARDIAC / HEART
- ❑ DEPRESSION
- ❑ DIABETES
- ❑ DERMATOLOGY
- ❑ SEIZURE DISORDER
- ❑ GASTROINTESTINAL
- ❑ PULMONARY
- ❑ MENTAL ILLNESS
- ❑ HEARING / SIGHT
- ❑ OBESITY
- ❑ ORTHOPEDIC
- ❑ IMMUNE DISORDERS
- ❑ CHOLESTEROL
- ❑ ANOREXIA / BULIMIA
- ❑ BLOOD PRESSURE
- ❑ GENITOURINARY
- ❑ HEADACHES / MIGRAINE
- ❑ OTHER: _____

IV. REQUIRED MEDICATION, PHYSICAL LIMITATIONS, SPECIAL NEEDS

_____

_____

_____

_____