

# John A. Gupton Student Health Form



## General Information

Name

\_\_\_\_\_  
Last First MI

Address

\_\_\_\_\_  
Street City State Zip

Phone

\_\_\_\_\_

Date of Birth

\_\_\_\_\_

SSN

\_\_\_\_\_

Male

\_\_\_\_\_

Female

\_\_\_\_\_

Citizenship

USA \_\_\_\_\_ Other \_\_\_\_\_  
Specify

Height

\_\_\_\_\_

Weight

\_\_\_\_\_

Hair Color

\_\_\_\_\_

Eye Color

\_\_\_\_\_

Emergency Contact

\_\_\_\_\_

Relationship

\_\_\_\_\_

Phone

\_\_\_\_\_

## Health Care Provider Information (REQUIRED)

Complete this section if you were born AFTER 1957

1. TB Skin Test or Chest X-Ray  
(MUST be within last year)

Date given

\_\_\_\_\_

Results

\_\_\_\_\_

2. 1st dose Rubeola, Rubella, Mumps vaccination

Date MMR given

\_\_\_\_\_

3. 2nd dose Rubeola, Rubella, Mumps vaccination

Date MMR given

\_\_\_\_\_

Health care providers signature or stamp

\_\_\_\_\_

Complete this section if you were born IN or BEFORE 1957

TB Skin Test or Chest X-Ray  
(MUST be within last year)

Date given

\_\_\_\_\_

Results

\_\_\_\_\_

Health care providers signature or stamp

\_\_\_\_\_

## Immunizations (advised but not required)

Tetanus (OR) TD \_\_\_\_\_ (Must be within the last 10 years)

Hepatitis B Series

1st \_\_\_\_\_

2nd \_\_\_\_\_

3rd \_\_\_\_\_

## Physical Findings - check any problems which require on-going care

\_\_\_ Allergy

\_\_\_ Dermatology

\_\_\_ Hearing/Sight

\_\_\_ Anorexia/Bulimia

\_\_\_ Anemia

\_\_\_ Seizure disorder

\_\_\_ Obesity

\_\_\_ Blood Pressure Hyper/Hypo

\_\_\_ Cardiac/Heart

\_\_\_ Gastrointestinal

\_\_\_ Orthopedic

\_\_\_ Genitourinary

\_\_\_ Depression

\_\_\_ Pulmonary

\_\_\_ Immune disorders

\_\_\_ Headaches/Migraine

\_\_\_ Diabetes

\_\_\_ Mental Illness

\_\_\_ Cholesterol

Other: \_\_\_\_\_

## Required medication, physical limitations, special needs

\_\_\_\_\_  
\_\_\_\_\_

