



Medical History and Physical Examination

All students need to fill out a Medical History Form and return by August 1.

All information received by the Student Health Service is kept in strict confidence in your personal medical file; hence, no pertinent information should be withheld. Medical files are confidential and information can be released only upon your written consent.

Part 1: To be completed by the student

Name: Last (Family) First (Given) Middle Initial Social Security No.: (if applicable)

Permanent Home Address: Street or RFD City State/Province & Country Zip Code

Date of Birth: Country of Birth:

Emergency Contact: Last (Family) First (Given) Middle Initial Home Phone:

Does this person speak fluent English? Yes No Work Phone:

Address of Above (Same or): Relationship:

Family Health History

Has anyone in your family ever had—or have now—any of the following?

Table with 8 columns: Check Each Item, Yes, No, Relationship, Check Each Item, Yes, No, Relationship. Rows include Tuberculosis, Diabetes, High Blood Pressure/Stroke, Heart Trouble, Cancer, Asthma, Hay Fever, Hives, Epilepsy or Convulsions, Nervous or Mental Disease.

Personal Health History

Have you ever had or have now any of the following (in lines of multiple statements cross out the inapplicable words.)

Explain all positive answers below.

Table with 12 columns: Check Each Item, Yes, No, Yes, No, Yes, No, Yes, No, Yes, No. Rows include Heart Trouble, High or Low Blood Pressure, Rheumatic Fever or Scarlet Fever, Cold Sores or Herpes, Diphtheria, Mumps, Whooping Cough, Measles, Chicken Pox, Mononucleosis, Smoke, and various conditions like Tuberculosis, Stomach or Intestinal Trouble, Jaundice or Liver Disease, Appendicitis, Rupture or Hernia, Skin Disease Boils, Painful or Trick Shoulder, Trick or Locked Knee, Arthritis, Bone or Joint Problem, Any Drug Side Effects, Thyroid, Surgery, Malaria, Dizzy or Fainting Spells, Epilepsy or Convulsions, Drink Alcohol Regularly, Emotional Problems, Sugar or Album in in Urine, Kidney or Bladder Trouble, Diabetes, See a Doctor Regularly.

If yes, or any other disease, give details:

Do you plan to participate in a sport? If yes, what sport?

Has your health been Good Fair Poor If not Good, explain

I am capable of safely participating in vigorous physical activity offered through physical education, intramural, and intercollegiate athletics unless otherwise noted in this Health Inventory. Yes No. If no explain

Statement of Authorization

I authorize and request Marietta Memorial Hospital to administer out-patient medical, surgical, services and immunizations and to perform emergency procedures, as necessary, or to refer to duly licensed medical personnel when indicated including transfer to outside hospitals.

Also, I authorize any physician, practitioner, clinic or hospital to furnish to Marietta Memorial Hospital all information concerning my case history and the treatment, examinations or hospitalization which I received in the past, including copies of hospital and medical records.

In case of illness or accident deemed serious by the Director of Health Service or the College physician(s), I authorize said persons to notify the parent or guardian named on this form, and the Dean of Students office if I am unable to do so. I hereby authorize the College physician(s) or Director of Health Service operating under physician's protocol to hospitalize me in case of emergency.

Signature of Student

Date

Signature of Parent or Guardian (if student is less than 18)

Date

Physical Examination (not required, but highly recommended)

Print Name: _____ Date: _____
 Sex: _____ Height: _____ Build: Slender _____ Heavy _____ Blood Pressure _____
 Age: _____ Weight: _____ Medium _____ Obese _____ Pulse _____
 _____ Color Vision _____ Hearing: Right _____ 15 Left: _____ 15

Vision:

Without Glasses: Right 20/ _____ Left 20/ _____

With Glasses: Right 20/ _____ Left 20/ _____

If correction is needed, please refer immediately.

Clinical Evaluation

Check each item in proper column, enter "N.E." if not evaluated	Normal	Ab-Normal	Note: Give details of each abnormality, enter corresponding number before each comment
1. Head, Neck, Face and Scalp			<p style="text-align: center;">Required (Ohio Revised Code, Sec. 3701.133, 1B)</p> <p>Meningitis Vaccine _____ _____ date</p> <p>Hepatitis B Vaccine 1. _____ _____ date 2. _____ _____ date 3. _____ _____ date</p>
2. Nose and Sinuses			
3. Mouth, Teeth, Gingiva, and Throat			
4. Ears—General (Canals, Drums, etc.)			
5. Eyes—General (lids, pupils, motions, etc.)			
6. Lungs, Chest, and Breasts			
7. Heart (include estimate of Cardiac Function)			
8. Vascular System (include Varicosities)			
9. Abdomen and Viscera (include Hernia)			
10. Ano-Rectal and Pilonidal			
11. Endocrine System			
12. Genito-Urinary System			
13. Upper Extremities			
14. Lower Extremities			
15. Spine, Other Musculoskeletal			
16. Skin and Lymphatic (include Acne)			
17. Neurological System			
18. Psychiatric (specify any personality deviation)			
19. Urinalysis			
20. If Female, give Menstrual History—Specify Medication			
Do you feel this student is physically able to participate in intercollegiate sports?	Yes	No	Tuberculin Test: In past 6 months _____ Date _____ _____ Neg _____ Pos. _____
Any history of emotional illness?	Yes	No	Immunization History
Present _____	Yes	No	Last Booster—Month and Year _____
Past _____	Yes	No	Diphtheria _____ Mumps _____
Allergies	Yes	No	Tetanus _____ Rubella _____
Drugs _____	Yes	No	Measles _____ Rubella Screening _____
Food _____	Yes	No	Polio _____
Special instructions for the Health Center while the student is in school?			_____ Physicians Signature _____ Date _____
Is student on any medication?			_____ Also, please print, stamp or type name
If so, what? _____			_____ Address
Explain all yes answers above and/or use for additional comments:			_____ City _____ State _____ Zip Code _____

HEALTH INSURANCE INFORMATION

All international students at Marietta College are required to be covered by a health insurance plan. Unless exempted, all international students are enrolled with HTH Worldwide Services and their student accounts are billed.

If you believe that you have comparable coverage, please contact International Student Program at mcip@marietta.edu