Medical History Form

to be filled out by student or parents

Full Name ______________________________ **Birth Date** ________________ **Sex:** ☐M ☐F

Emergency Contact Info

Full Name ______________________________ Relationship to Applicant ________________

Cell Number ______________________________ Work Number ________________

Medical History

	Yes	No		Yes	No		Yes	No
Allergies	☐	☐	Eye trouble	☐	☐	Sickle cell trait/anemia	☐	☐
Anxiety	☐	☐	Head injury/concussion	☐	☐	Sinusitis	☐	☐
Asthma	☐	☐	Headaches/migraines	☐	☐	Sleeping difficulty/insomnia	☐	☐
Cancer	☐	☐	Heart murmur	☐	☐	Stomach/intestinal issues	☐	☐
Chicken pox	☐	☐	High/low blood pressure	☐	☐	Tuberculosis	☐	☐
Depression	☐	☐	Joint injury	☐	☐	Weakness/paralysis	☐	☐
Diabetes	☐	☐	Mumps/Measles	☐	☐	Weight gain/loss (recent)	☐	☐
Dizziness/fainting	☐	☐	Pneumonia	☐	☐	Female students:		
Drug/alcohol abuse	☐	☐	Seizure disorder	☐	☐	Irregular periods	☐	☐
Eating disorder	☐	☐	Shortness of breath	☐	☐	Severe cramps	☐	☐

Any additional medical problems not listed above: ______________________________

If you checked yes on any above, please explain:

____

Current medications (if any): ______________________________

Drug allergies (if any): ______________________________

List any special dietary needs: ______________________________

Immunization record

Minnesota law requires proof that students enrolling in college be immunized against diphtheria, tetanus, measles, mumps, and rubella. (M. S. 135.14)

	Yes	No	Date of last injection
Td/Tdap	☐	☐	________________
MMR	☐	☐	________________

Insurance Information

Health insurance or membership in a health-sharing ministry is required.

Attach a photocopy of your **health insurance/health-sharing membership** card to this form.

Insurance/Health Sharing Company ____________ Group #: ____________ Policy #: ____________

Student signature

I have answered the questions on the Medical History Form to the best of my ability. Also, I understand that I am financially responsible for all medical expenses not covered by my insurance.

Signed ______________________________ Date ________________

Physical Examination Form

to be filled out by MD, DO, PA, or NP

Pre-Examination

Height __________ Weight ___________ H.R. _________ B.P. ___________ R.R. ___________Temp. ___________

Hearing (right) _____________ (left) ____________ Corrected vision (right) 20/ __________ (left) 20/ __________

Clinical Evaluation

	Normal	Abnormal	Comments
EENT	☐	☐	________________
Head/neck	☐	☐	________________
Lungs/chest	☐	☐	________________
Heart/CVS	☐	☐	________________
G. I./Abdomen	☐	☐	________________
Neuropsychiatric	☐	☐	________________
Nutrition	☐	☐	________________

Other comments: ____

____

Current medications: ____

____

Physician Signature

I certify that ______________________________________ has been medically evaluated and my professional recommendation is that he/she is physically capable to:

Yes	No	
☐	☐	Pursue a full-time post-secondary program.
☐	☐	Play intramural and intercollegiate sports.

Printed Name: ____

Signed: ____ Date: ____________________

Name of Clinic: ____ Phone Number: ____________________

MAIL THE COMPLETED MEDICAL HISTORY AND PHYSICAL EXAMINATION FORMS TO

AFLBS Office of Admissions

3134 E Medicine Lake Blvd

Plymouth, MN 55441

Phone: (763) 544-9501

Email: admissions@aflbs.edu