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 OR EMAIL THESE FORMS AND A COPY OF YOUR INSURANCE CARD TO

FLBC Office of Admissions
3134 E Medicine Lake Blvd
Plymouth, MN 55441

Email: admissions@flbc.edu
Phone: (763) 544-9501