UNIVERSITY OF RIO GRANDE AND RIO GRANDE COMMUNITY COLLEGE

Student ID:
Enrolled In: (please check one) ☐ DMS ☐ Allied Health
☐ Nursing
☐ Respiratory
☐ Rad Tech

STUDENT CONFIDENTIAL MEDICAL HISTORY FORM

Today's Date _____ Social Security Number _____ Date of Birth _____

Last Name (please print) First Middle Home: ( ) Cell: ( ) Telephone

Street Address City State Zip Code

Physician's Name Address ( ) Telephone

EMERGENCY CONTACT: _____
Name of Person to be Notified Relationship to You

Street Address City State Zip Home: ( ) Cell: ( ) Telephone

Family Medical History: Give Age and Health Condition of the Following (excellent, good, fair, poor)
Father _____ Mother _____ Sister(s), Brother(s) _____
Spouse _____ Children _____

Personal Medical History: Please check YES or NO. If YES, please explain further in the space provided.

CONDITION:	*YES*	*NO*	*CONDITION:*	*YES*	*NO*
Allergies: Medicinal			Hearing Defect		
Seasonal			Heart Disease		
Mental Health			High Blood Pressure		
Allergic Reaction			Kidney Disease		
Back Problems			Lift at least 25 lbs		
Bleeding Tendency			Nervous Condition		
Cancer			Recurrent Headaches		
Chronic Back Pain			Rheumatic Fever		
Chronic Lung Disease			Serious Illness		
Diabetes/Type 1 - 2			Serious Injury		
Epilepsy			Surgical Operation		
Eye Defect			Thyroid Disorder		

Insurance Information: Do you have insurance? YES ☐ NO ☐ If yes, please ATTACH the following information:
1. Name and Address of Insurance Company
2. Policy Certificate Number
3. Group Number
4. Insured Person's Name and Relationship
5. Name and Address of his/her employer

I certify that the above medical information is true to the best of my knowledge and I give consent for the administration of medicines and treatment procedures as recommended by the medial personnel of the University of Rio Grande. Consent is also granted to a licensed physician, surgeon, or dentist for necessary treatment.

Signature of Student _____ **Signature of Guardian (under 18)** _____
Date _____ **Date** _____

STUDENT CONFIDENTIAL MEDICAL HISTORY FORM *continued*

HEALTH EVALUATION: *(To be completed by a physician)* **All Items Must Be Complete Before Returning Form**

Last Name (please print) First Middle Home: ( ) Cell: ( ) Telephone

Gender / Blood Pressure (sitting) Age Height Weight Corrected Vision: 20/ Right 20/ Left Hearing: /15 Right /15 Left

Color Blind yes/no

REQUIRED: A TUBERCULIN SKIN TEST (TB, PPD, TST)

Date Test Read:_____ Negative ☐ Positive ☐

Chest X-Ray Date: (*If test is positive)* _____

BCG Immunization: Yes ☐ No ☐ Date_____

IMMUNIZATION / DISEASE RECORDS: ATTACH A COPY OF IMMUNIZATION RECORDS AS PROOF

Diptheria-Tetanus (Tetanus Booster, Tdap) ***Most recent must be within the last ten (10) years*****:** _____

*Mumps, Measles, Rubella (German), Rubeola (Red), MMR: #1 _____ #2 _____

Hepatitis B Vaccine *(Does not apply to international students)*: #1 _____ #2 _____ #3_____

Polio Series: Salk ☐ Oral ☐ Date_____

Have you had chickenpox? Yes ☐ No ☐

**If you are unable to provide proof of immunization, a titer MUST be done for Rubella, Rubeola, and Mumps.*

IRREGULARITIES:	*YES*	*NO*	*IRREGULARITIES:*	*YES*	*NO*
Able to Lift 20 lbs	☐	☐	Metabolic/Endocrine	☐	☐
Cardiovascular	☐	☐	Musculosketal	☐	☐
Eyes (excluding acuity)	☐	☐	Neuro Psychiatric	☐	☐
Gastrointestinal	☐	☐	Respiratory	☐	☐
Genitourinary	☐	☐	Skin	☐	☐
Head, Ears, Nose, Throat	☐	☐	Taking Meds (Rx or nonRx)	☐	☐
Hernia	☐	☐	Teeth	☐	☐
Menstrual	☐	☐	Walking distances	☐	☐

Do you have any special instruction(s) for the University of Rio Grande/Rio Grande Community College Health Services Office regarding the above student? Is the student free and clear of medical restrictions?

_____

_____

Physician's Name: *(Type, Print, or Stamp)*_____

Office Address: _____

Office Telephone: _____

Physician's Signature: _____ Date of Examination:_____

PLEASE RETURN FORM AND ATTACHMENTS TO:
Your Clinical Coordinator listed below
Nursing: Donna Walker dwalker@rio.edu Fax: 740-245-7177
Rad Tech: Rachel Payne rpayne@rio.edu Fax: 740-245-7440
DMS: Laura Rupe lrupe@rio.edu Fax:740-245-7440
Respiratory: Christina Miller cmiller@rio.edu Fax: 740-245-9465
Allied Health: Megan Mullins mmullins@rio.edu Fax 740-245-7440