Medical Form

Name

Address | City | State | Zip

Marital Status ☐ Single ☐ Married | Age | Gender ☐ Male ☐ Female

Date of Birth MM/DD/YYYY | Occupation | ☐ Part-time Student ☐ Full-time Student

Personal History *(Check all that apply. If yes, give the date of the most recent symptoms.)*

- ☐ Drug Abuse _____
- ☐ Diabetes _____
- ☐ Seizures _____
- ☐ Rheumatic Fever _____
- ☐ Arthritis _____
- ☐ Skin Problem _____
- ☐ High Blood Pressure _____
- ☐ Heart Disease _____
- ☐ Tuberculosis _____
- ☐ Thyroid Disease _____
- ☐ Anemia _____
- ☐ Scoliosis _____
- ☐ Back Injury _____
- ☐ Mumps/Measles _____
- ☐ Chicken Pox _____
- ☐ Venereal Disease _____
- ☐ Kidney Disease _____
- ☐ Liver Disease _____
- ☐ Stomach Ulcer/Gastritis _____
- ☐ Gallbladder Disease _____
- ☐ Allergies _____
- ☐ Pneumonia _____
- ☐ Asthma _____
- ☐ Migraine Headaches _____
- ☐ Previous Pregnancies _____
- ☐ Sexually Transmitted Disease _____ (condyloma, HIV positive)

Do you take any medications regularly? ☐ Yes ☐ No *(If yes, please list them.)*

Have you had any surgeries? ☐ Yes ☐ No *(If yes, please list them.)*

Have you ever sought psychiatric/psychological counsel? ☐ Yes ☐ No *(If yes, please list below.)*

Name of Doctor | City | State

Name of Facility | City | State

Dates of Care

IMMUNIZATIONS *(give month, day, and year.)*

DPT (Diphtheria, Tetanus, Whooping Cough)

OPV (Oral Polio)

Measles (Rubeola)

German Measles (Rubella)

Mumps

HYLES ANDERSON
COLLEGE

PLEASE SUBMIT FORMS TO THE OFFICE OF ADMISSIONS
8400 Burr Street | Crown Point, IN 46307
888.374.9537 ph | 219.365.2029 fax

If you have questions, please call us at 888.374.9537 or visit us online at hylesanderson.edu.
hylesanderson.edu | facebook.com/hylesanderson

Physical Form

TO THE APPLICANT: This form must be completed by your physician no more than one year before you enroll.

The deadline for submitting a complete physical form is thirty days after the first day of registration for the first semester enrolled if you are a full-time and/or dorm student. A complete physical form includes this form AND the results from the Tuberculin PPD test AND, if this test is positive, the **results** from the chest X-ray.

These tests may cost up to $100 **or more** and may take up to 7-10 days **or longer** to complete. No matter the cost or the time required, it is the student's responsibility to submit a complete physical form before the above deadline.
No student will be allowed to attend any class after midterms **until his or her complete physical form has been submitted to the Admissions Office.**

TO THE PHYSICIAN: Every blank is required. Thank you for your assistance.

Name		Today's Date MM/DD/YYYY
Date of Birth MM/DD/YYYY	Height	Weight
Temperature	Pulse	Blood Pressure
Vision (without glasses)	Right	Left
Vision (with glasses)	Right	Left
Urine	Sugar	Ketone

Tuberculin PPD (mantoux): Date Given	Date Read MM/DD/YYYY	Results*
*If positive, chest X-ray:	Date Read MM/DD/YYYY	Results

This test is required.

General Appearance	☐ Good	☐ Fair	☐ Poor
Skin	Reoccuring skin problems?		
Ears	Heart		Nose/Throat
Lungs	Asthma?	☐ Yes	☐ No
Abdomen	Hernias?	☐ Yes	☐ No
Gynecological History			
Extremities			
Orthopedic			
General Comments			
Does this person seem to be capable of being enrolled in college?		☐ Yes	☐ No
Physician's Signature			
Physician's Name			
Address		City	State Zip
Phone ( ) -			

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