COLUMBUS TECHNICAL COLLEGE
THE SCHOOL OF HEALTH SCIENCES

MEDICAL FORM

Name ____ *SS or Student ID #* ___________________________

Address ____
City *State* *Zip*

Program of Intent: ____ *Expected Entrance Date*_______________

Height _________ *Weight* _______ *Posture* __________ *Gender: Male* _______ *Female*_______ *Pulse* ____ *B/P* ____________

HISTORY

Place a check mark by any conditions that apply to this student:

Diabetes		Asthma		Kidney Disease	
Arthritis		Heart Disease		Lung Disease	
High Blood Pressure		Angina Pectoris		Venereal Disease	
Low Blood Pressure		Hepatitis		Hemophilia	
Anemia		Rheumatic Fever		Other Blood Disease	
Heart Murmur		Thyroid Disease		Ulcers	
HIV/AIDS		Cancer		Arterial Disease	
Heart Pacemaker		Jaundice		Depression	
Artificial Joint		Convulsions		Paralysis	
Artificial Heart Valve		Frequent Headaches		Bleeding Problems	
Shortness of Breath		Frequent Urination		Weight Loss	

Other Serious Illnesses Not Listed ____

Explanation/history of any checked above:____

____

List any previous surgery with year ____

____

PHYSICAL EXAM

Eyes & Vision _____________ *Color Blind Test* _______________*Ears & Hearing* __________________ *Throat* __________

*Teeth*___________ *Skin*___________________ *Nose*___________________ *Breast* ________________*Mouth* ___________

Sinuses ___________*Neck* _______________*Thyroid* __________________ *Heart* ________________ *Lungs* _____________

Abdomen _________ *G.U. System* _____________*Genitalia* ____________*Rectal* _____________ *Extremities* _____________

Urinalysis ________________________________ *Hemoglobin* ____________________ *Blood Serology* _________________

Other Findings ____

PPD Results ___________________ *X-Ray findings if Positive* ____

Last Tetanus Booster: ___________

Comments on applicant's physical and mental health, which should be brought to the attention of the college:

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Check One:

_____ *In my opinion, Applicant is able to participate in the* _______________________________________ *program at CTC*

_____ *In my opinion, Applicant is* ***NOT*** *able to participate in the* __________________________________ *program at CTC*

Signature of person completing the exam:

____

Circle One: Physician Physician Assistant Advanced Practice Nurse

Address:

____

____

Date: ____________________

This form must be mailed directly to:

The School of Health Sciences
Columbus Technical College
928 Manchester Expressway
Columbus, Georgia 31904-6572

REV 6/08