Western Texas College
Medical Form

****THIS FORM IS NOT VALID UNLESS SIGNED BY A PHYSICIAN****

Please Print
Name:_____
SSN:_____

Section I: Personal History-Please answer all questions. Comment below.

HAVE YOU HAD	YES	NO		YES	NO		YES	NO
Head or Spinal Injuries			Epilepsy			Incurable Disease		
Encephalitis			Tuberculosis			Allergic to Medication		
Heart Disease			Stomach Ulcer			Allergic to Inoculation		
Venereal Disease			Asthma			Anxiety or Depression		
Diabetes			Kidney Disease			Worry or Nervousness		
Permanent Defect			Rheumatic Fever					

Comment on the positive answers above._____
_____

A. What is the status of your general health now? Explain._____
_____

B. Do you have convulsions? If so, explain._____
_____

C. Name any medications you take regularly._____
_____

D. Do you have a physical or nervous condition, which you believe would prevent you from participation in physical education? If so, please describe the conditions fully._____
_____

E. Have you received treatment or counseling for a nervous condition, personality disorder, or emotional problem? If so, explain._____
_____

Section II: A physician must complete this section.

BP_____/_____
Height_____inches
Weight_____lbs.
Overweight_____
Underweight_____
Corrected Vision:Right 20/_____Left 20/_____
(RECOMMENDED)
Tuberculin Skin Test: Pos_____ Neg_____
Urinalysis: Sugar_____ Albumin_____
Micro_____

Are there any abnormalities of the systems below? Describe fully.

	YES	NO		YES	NO
Head, Ears, Nose, and Throat			Genitourinary		
Respiratory			Musculoskeletal		
Cardiovascular			Metabolic/Endocrine		
Gastrointestinal			Neuropsychiatric		
Hernia			Skin		
Eyes					

Is there loss or seriously impaired function of any paired organ? Yes___No____

Recommendations for physical activity (PE, Intramurals, Varsity Sports)
Unlimited_____ Limited_____
Explain:_____

Do you have recommendations regarding the case of this student? Yes___No___

Is the student now under treatment for any medical or emotional condition?
Yes_____ No_____
Explain:_____

_____ _____
Physician's Name Physician's Signature

_____
Address City State Zip

_____ _____
Student's Name Student's Signature

_____ _____
Phone Number Date

Revised: June 8, 2010