

MEDICAL EVALUATION FORM  
PART 1

To be completed by student and submitted to the examining physician before he examines the student.

Student: \_\_\_\_\_ Parent \_\_\_\_\_  
           Last                      First                      Middle

Date of Birth \_\_\_\_\_ Address \_\_\_\_\_

School \_\_\_\_\_ Seminole State College \_\_\_\_\_ Phone \_\_\_\_\_

PERSONAL HEALTH OF STUDENT

Circle Correct Response

- |   |     |    |
|---|-----|----|
| 1. Has had injuries or accidents requiring medical attention.....       | YES | NO |
| 2. Has had a surgical operation.....                                    | YES | NO |
| 3. Has been in a hospital.....  | YES | NO |
| 4. Has had sickness lasting longer than one week.....                   | YES | NO |
| 5. Takes medicine now or regularly.....                                 | YES | NO |
| 6. Has a condition now under a physician's care.....                    | YES | NO |
| 7. Any defect of hearing or eyesight? Wear glasses, contact lenses..... | YES | NO |
| 8. Any reason this student should not take part in any sport.....       | YES | NO |
| 9. If "YES" to any question, explain her with names and dates: _____    |     |    |

- |  |     |    |
|--|-----|----|
| 10. Has had complete poliomyelitis immunization by injections (Salk) or vaccine<br>by mouth (Sabin)..... | YES | NO |
| 11. Has had tetanus toxoid and booster inoculation within the past 3 years.....                          | YES | NO |
| 12. Has seen a dentist within the past 6 months.....   | YES | NO |
| 13. To my knowledge the paired organs that follow are present and healthy:                               |     |    |
| Eyes.....  | YES | NO |
| Ears.....  | YES | NO |
| Lungs.....   | YES | NO |
| Kidneys.....   | YES | NO |
| Testicles or ovaries.....  | YES | NO |
| Arms/legs.....   | YES | NO |
| Fingers/toes.....  | YES | NO |

If "NO" to any of the questions, explain her with names and dates: \_\_\_\_\_

\*If a tetanus booster is indicated, I give my permission for such an inoculation to be administered by the examining physician. \_\_\_\_\_

Signature

