



**Medical/Health Form  
Dual/High School  
PENSACOLA CHRISTIAN COLLEGE**  
P.O. Box 18000 • Pensacola, FL 32523-9160 • U.S.A.

<b>OFFICE USE ONLY:</b>	Term _____
I.D. No. _____	Box _____
Incomplete _____ / _____	Complete _____ / _____
Scanned _____	

**\*\*\*This form must be completed fully before registering for classes.\*\*\***

**Student Information:**

NAME: Last		First	Middle	BIRTH DATE ____/____/____ Month Day Year
PERMANENT ADDRESS			CITY	STATE/ZIP
HOME PHONE NUMBER ( )	CELL PHONE NUMBER ( )	SEX (circle one) male female		U.S. CITIZEN (circle one) yes no

**Family Information:**

Father's Name \_\_\_\_\_ Age \_\_\_\_\_  
 Father's Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Home address and phone number if different from above: \_\_\_\_\_

List any major health problems: \_\_\_\_\_  
 Deceased? Y / N Cause of death \_\_\_\_\_

Mother's Name \_\_\_\_\_ Age \_\_\_\_\_  
 Mother's Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Home address and phone number if different from above: \_\_\_\_\_

List any major health problems: \_\_\_\_\_  
 Deceased? Y / N Cause of death \_\_\_\_\_

Number of Siblings \_\_\_\_\_ Number deceased \_\_\_\_\_ Cause of death \_\_\_\_\_  
 List any major health problems: \_\_\_\_\_

**Emergency Contact:** (person to contact if parents cannot be reached)

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Insurance Information:**  I am not covered by health insurance.

Name of Insurance Company \_\_\_\_\_  
 Address \_\_\_\_\_  
 Customer Service 800 No. \_\_\_\_\_ Prescription 800 No. \_\_\_\_\_  
 Name on Insurance Card \_\_\_\_\_ Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_  
 \*Please make a copy of both sides of your insurance card and send with form.

**Primary Care Physician:**

Physician Name \_\_\_\_\_ Phone No. \_\_\_\_\_  
 Address \_\_\_\_\_ Fax No. \_\_\_\_\_

**Personal Health History:**

List all allergies to foods, medications, etc. If yes list: \_\_\_\_\_

\_\_\_\_\_

List **all medications** taken on a regular basis including over-the-counter medication:

<i>Medication name</i>	<i>Dosage</i>	<i>When taken (daily, weekly, monthly)</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any hospital stays you have had:

<i>Date(s) of stay</i>	<i>Reason for stay</i>
_____	_____
_____	_____

List any surgeries you have had (both inpatient and outpatient)

<i>Date of surgery</i>	<i>Reason for surgery</i>
_____	_____
_____	_____

**Do you have or have you ever had any of the following: Check ONLY if YES**

	<b>Condition</b>	<b>Date(s)</b>	<b>Y</b>		<b>Condition</b>	<b>Date(s)</b>	<b>Y</b>
1	Asthma			19	Liver disease/disorder		
2	Brain disease/disorder			20	Measles		
3	Cancer/tumors			21	Menstrual difficulties		
4	Chicken pox			22	Mumps		
5	Chronic back disorder			23	Muscular disease/disorder		
6	Chronic diarrhea/constipation			24	Physical limitations		
7	Chronic headaches			25	Polio		
8	Depression/anxiety			26	Pregnancy		
9	Diabetes			27	Psychiatric disorder		
10	Disease/disorder sexual organs			28	Skeletal disease/disorder		
11	Ear disease/disorder			29	Skin disease/disorder		
12	Eating disorder			30	Speech disorder		
13	Emotional disorder			31	Spine disease/disorder		
14	Epilepsy/seizures			32	Stomach disease/disorder		
15	Eye disease/disorder			33	Tuberculosis		
16	Heart disease/disorder			34	Wheelchair		
17	High/low blood pressure			35	Other:		
18	Kidney disease/disorder						

Explain yes answers \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I attest that the information presented by me on this health form is true and accurate to the best of my knowledge. I understand that this form is necessary for admission to this college and that falsification of information could result in dismissal from college.

Signature of applicant \_\_\_\_\_ Date \_\_\_\_\_

\*Pensacola Christian College reserves the right to refuse enrollment to any applicant whose health record indicates the existence of a condition which may be harmful to the members of the college community.

## Medical/Health Form Dual/High School

Name \_\_\_\_\_ Birth Date \_\_\_/\_\_\_/\_\_\_ Male \_\_\_ Female \_\_\_  
(Last) (First) (Middle)

### Record of Immunization Requirements for Admission:

All appropriate doses and dates must be entered and documents must include the applicant name.

Vaccine	Dose 1 Date	Dose 2 Date	Dose 3 Date	Dose 4 Date	Dose 5 Date
DTaP (diphtheria,- tetanus-pertussis)	___/___/___ M D Y	___/___/___ M D Y	___/___/___ M D Y	___/___/___ M D Y	___/___/___ M D Y
Tdap (tetanus- diphtheria-pertussis) (11 years and older)	___/___/___ M D Y				
Hepatitis B	___/___/___ M D Y	___/___/___ M D Y	___/___/___ M D Y		
Polio	___/___/___ M D Y	___/___/___ M D Y	___/___/___ M D Y	___/___/___ M D Y	
Measles Mumps Rubella (MMR)	___/___/___ M D Y	___/___/___ M D Y			
Varicella (chicken pox)	___/___/___ M D Y	Or Varicella Disease ___/___/___ M D Y			
Meningococcal Meningitis	___/___/___ M D Y	Recommended for all students (see below to decline this immunization)			

I have read the enclosed information and decline to receive the Meningococcal Meningitis vaccine. \_\_\_\_\_  
Signature  
(Parent/Guardian required for student under 18)

### INTERNATIONAL REQUIRED

**TB skin test required for all International applicants and US and Canadian citizens residing outside North America.**  
*(A TB skin test must be done no more than 12 months prior to admission/arrival on campus. If a TB skin test has ever been done and resulted as "positive," a negative chest x-ray is required. Those individuals whose most recent screening resulted as "positive" must have a negative chest x-ray within the 12 months following the TB skin test.)*

TB skin test (PPD) mm \_\_\_\_\_ Pos \_\_\_\_\_ Neg \_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_  
Month Day Year

A 6-9 month treatment of INH is recommended for any positive TB skin test.

TB treatment dates: Prophylactic INH \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_  
Month Day Year      Month Day Year

MD documentation that course of INH has been completed

TB skin test read by \_\_\_\_\_ Date \_\_\_\_\_ License No. Or Office Stamp With Address \_\_\_\_\_

## Physical Evaluation is required for all Dual/High School Enrollment

Name: \_\_\_\_\_ Date: \_\_\_\_\_

This Physical Evaluation must be completed ONLY by a Primary Care Provider.

**Screening Results:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

Vision - Without Correction	Right 20/ _____	Left 20/ _____	Hearing - Right	Passed <input type="checkbox"/> Failed <input type="checkbox"/> Referred <input type="checkbox"/>
Vision - With Correction	Right 20/ _____	Left 20/ _____	Hearing - Left	Passed <input type="checkbox"/> Failed <input type="checkbox"/> Referred <input type="checkbox"/>

Gross Dental (teeth and gums)	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Refer/Treatment
Head/Scalp/Skin	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Refer/Treatment
Eyes/Ears/Nose/Throat	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Refer/Treatment
Chest/Lungs/Heart	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Refer/Treatment
Abdomen	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Refer/Treatment
Postural Assessment	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Refer/Treatment

This student has the following problems that may affect the educational experience:

- Vision  
  Hearing  
  Speech/Language  
  Physical  
  Social/Behavioral  
  Cognitive

Specify: \_\_\_\_\_

- This student has a health condition (such as seizures or allergies) that may require emergency action at school.

Specify: \_\_\_\_\_

Recommendations (attach additional sheet if necessary): \_\_\_\_\_

(Please Check One)

- This student may participate in all school activities including physical education.
- This student may participate in all school activities including physical education with the following restriction/adaptation.  
 (Specify reason and restriction) \_\_\_\_\_

Signature/Title of Health Care Provider	Date	Address (Please print or stamp)

PHYSICIAN, NP, PA, or AP SIGNATURE

LICENSE NO. or OFFICE STAMP WITH ADDRESS

# Vaccination Information

## Meningococcal Vaccine

### 1. What is meningococcal disease?

Meningococcal disease is a serious illness caused by a bacteria. It is the leading cause of bacterial meningitis in children 2-18 years old in the United States. Meningitis is an infection of the brain and spinal cord coverings. Meningococcal disease can also cause blood infections.

About 2,600 people get meningococcal disease each year in the U.S. Ten to fifteen percent of these people die, in spite of treatment with antibiotics. Of those who live, another 10 percent lose their arms or legs, become deaf, have problems with their nervous systems, become mentally retarded, or suffer seizures or strokes.

Anyone can get meningococcal disease. **College freshmen, particularly those who live in dormitories, have a slightly increased risk of getting meningococcal disease.**

Meningococcal vaccine can prevent two of the three important types of meningococcal disease in older children and adults. Meningococcal vaccine is not effective in preventing all types of the disease, but it does help to protect many people who might become sick if they don't get the vaccine.

Drugs such as penicillin can be used to treat meningococcal infection. Still, about one out of every 10 people who get the disease dies from it, and many others are affected for life.

### 2. Who should get meningococcal vaccine?

College freshmen, especially those who live in dormitories, and their parents should discuss the benefits and risks of vaccination with their health care providers.

### 3. Who should get meningococcal vaccine?

People should not get meningococcal vaccine if they have ever had a serious allergic reaction to a previous dose of the vaccine. People who are mildly ill at the time the shot is scheduled can still get meningococcal vaccine. People with moderate or severe illnesses should usually wait until they recover. Your provider can advise you.

### 4. What are the risks from meningococcal vaccine?

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of the meningococcal vaccine causing serious harm, or death, is extremely small. Getting meningococcal vaccine is much safer than getting the disease. Some people who get meningococcal vaccine have mild side effects, such as redness or pain where the shot was given. These symptoms usually last for 1-2 days. A small percentage of people who receive the vaccine develop a fever.

### 5. How can I learn more?

- Ask your doctor or nurse or local health department.
- Contact the Centers for Disease Control and Prevention (CDC):
- Call 800.232.2522 (English) or 800.232.0233 (Spanish)
- Visit the National Center for Infectious Disease's meningococcal disease website at: [www.cdc.gov/ncidod/diseaseinfo/meningococcal\\_g.htm](http://www.cdc.gov/ncidod/diseaseinfo/meningococcal_g.htm)