

Medical History Form

to be filled out by student or parents

Full Name _____ Birth Date _____ Sex: M F

Emergency Contact Info

Full Name _____ Relationship to Applicant _____

Cell Number _____ Work Number _____

Medical History

	Yes	No		Yes	No		Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Eye trouble	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell trait/anemia	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Head injury/concussion	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping difficulty/insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/intestinal issues	<input type="checkbox"/>	<input type="checkbox"/>
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	High/low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Joint injury	<input type="checkbox"/>	<input type="checkbox"/>	Weakness/paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Mumps/Measles	<input type="checkbox"/>	<input type="checkbox"/>	Weight gain/loss (recent)	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<u>Female students:</u>		
Drug/alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Severe cramps	<input type="checkbox"/>	<input type="checkbox"/>

Any additional medical problems not listed above: _____

If you checked yes on any above, please explain:

Current medications (if any): _____

Drug allergies (if any): _____

List any special dietary needs: _____

Immunization record

Minnesota law requires proof that students enrolling in college be immunized against diphtheria, tetanus, measles, mumps, and rubella. (M. S. 135.14)

	Yes	No	Date of last injection
Td/Tdap	<input type="checkbox"/>	<input type="checkbox"/>	_____
MMR	<input type="checkbox"/>	<input type="checkbox"/>	_____

Insurance Information (please attach **proof of insurance/health care coverage** to this form)

Insurance Company _____ Group #: _____ Policy #: _____

Student signature

I have answered the questions on the Medical History Form to the best of my ability. Also, I understand that I am financially responsible for all medical expenses not covered by my insurance.

Signed _____ Date _____

Physical Examination Form

to be filled out by MD, DO, PA, or NP

Pre-Examination

Height _____ Weight _____ H.R. _____ B.P. _____ R.R. _____ Temp. _____

Hearing (right) _____ (left) _____ Corrected vision (right) 20/ _____ (left) 20/ _____

Clinical Evaluation

	Normal	Abnormal	Comments
EENT	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head/neck	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs/chest	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart/CVS	<input type="checkbox"/>	<input type="checkbox"/>	_____
G. I./Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuropsychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other comments: _____

Current medications: _____

Physician Signature

I certify that _____ has been medically evaluated and my professional recommendation is that he/she is physically capable to: (check all that apply)

Yes No

Pursue a full-time post-secondary program.

Play intramural and intercollegiate sports.

Printed Name: _____

Signed: _____

Date: _____

Name of Clinic: _____

Phone Number: _____

MAIL THE COMPLETED MEDICAL HISTORY AND PHYSICAL EXAMINATION FORMS TO

AFLBS Office of Admissions

3134 E Medicine Lake Blvd
Plymouth, MN 55441

Phone: (763) 544-9501

Email: aflbs@aflc.org