# LENOIR COMMUNITY COLLGE
## INTERNATIONAL (F-1) STUDENT MEDICAL FORM

**To the Student:** Please take this form to your physician or clinic for completion.
**Important:** The following sections must be completed before submitting this form to the Admissions Office. Health forms lacking completion of these sections will not be considered valid. **Failure to submit a valid health form by the indicated deadline will result in your admission application being incomplete.** Students should make and retain a copy of their health forms for their personal records prior to submitting it to the College. A physician, physician assistant, or nurse practitioner must complete your physical exam.

**REPORT OF MEDICAL HISTORY REPORT OF MEDICAL HISTORY**
(Please print in black Ink) To be completed by student

___________________________________________________________________
Last Name (print) First Name Middle Name

___________________________________________________________________
Permanent Address City State Zip Code Area Code/Phone Number

Date of Birth (mo/day/yr) _______________ Gender _____M _____F Martial Status _____S _____M _____Other

Previously enrolled here _____Yes _____No
If yes, dates __________________________ Semester Entering: _____Fall _____Spring _____Summer

___________________________________________________________________
Hospital/Health Insurance (Name and Address of Company) Area Code/Phone Number

___________________________________________________________________
Name of Policy Holder Employer

__________________________________________
Policy or Certificate Number Group Number Is this an HMO/PPO/Managed Care Plan? _____Yes _____No

___________________________________________________________________
Name of person to contact in case of an emergency Relationship

___________________________________________________________________
Address City State Zip Code Area Code/Phone Number

The following health history is confidential, except in an emergency situation or by court order, will not be released without your written permission. Your health history does not affect your admission status. Please attach additional sheets for any items that require fuller explanation.

**Personal Health History**
Please answer all questions, indicate comments on all positive answers on a separate paper.

| HAVE YOU HAD | YES | NO | | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Eye Trouble | | | Frequent or Severe Respiratory Infections | | | Kidney or Bladder Disease | | | Diaseses | | |
| Ear, Nose, Throat Trouble | | | Rheumatic Fever or Heart Mummer | | | Disease or injury of Bones or Joints | | | Infectious | | |
| Frequent or Severe Headaches | | | Stomach or Intestinal Trouble | | | "Tick" Knee, Shoulder, etc. | | | Female Only | | |
| Epilepsy | | | Hepatitis or jaundice | | | Anemia | | | Irregular Periods | | |
| Asthma, High Fever | | | | | | | | | Severe Cramps | | |
| Tuberculosis | | | | | | | | | Extensive Flow | | |

| | YES | NO | Explanation |
|---|---|---|---|
| Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe) | | | |
| Have you ever been a patient in any type of hospital? (Specify when, where, and why) | | | |
| Has your academic career been interrupted due to a physical or emotional problems? (Please explain) | | | |
| Is there loss or seriously impaired function on any paired organs? (Please describe) | | | |
| Other than for a routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe) | | | |
| Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details) | | | |

Important Information….Please read and complete statements by student (or parent/guardian, if student under age 18):

I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter's) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

_______________________________________________ ______________________
Signature of Student Date

_______________________________________________ ______________________
Signature of Parent/Guardian, if student under age 18 Date

## Physical Examination (required)

(Please print in black ink.) To be completed and signed by physician or clinic

Last Name _______________ First Name _______________ Middle Name _______________ Date of Birth _______________

Permanent Address _______________ City _______________ State _______________ Zip Code _______________ Area Code/Phone Number _______________

Height ________ Weight _________ BP _____/_____ Pulse ______ /min

Vision: Corrected Right 20/ _____ Left 20/ _____ Hearing (gross) Right _______
Uncorrected Right 20/ _____ Left 20/ _____ Left _______

Urinalysis

Sugar __________

Albumin _______

Micro _________

Hematocrit

_________%

| Are there abnormalities? | Normal | Abnormal | IMMUNIZATIONS | mo/day/yr (#1) | mo/day/yr (#2) | mo/day/yr (#3) | mo/day/yr (#4) |
|---|---|---|---|---|---|---|---|
| Head, Ears, Nose Throat | | | DTP or TD(within last five years) | | | | |
| Eyes | | | TD Booster | | | | |
| Respiratory | | | Polio | | | | |
| Cardiovascular | | | MMR (after first birthday) | | | | |
| Gastrointestinal | | | MR (after first birthday) | | | | |
| Hernia | | | Measles (after first birthday) | | | | |
| Genitourinary | | | Mumps | | | | |
| Musculoskeletal | | | Rubella | | | | |
| Metabolic/Endocrine | | | BCG Vaccine | | | | |
| Neuropsychiatric | | | **(Please note: IF YOU HAVE NOT HAD THE BCG VACCINE, A TB test is required and must be administered within the last 12 months. Tuberculin(PPD) Test Date Read (within12 months) mm induration** | | | | |
| Skin | | | Chest X-ray, if positive PPD Date<br>Results | | | | |
| Mammary | | | Treatment, If applicable Date | | | | |

A. Is there loss or seriously impaired functions on any paired organs? Yes _____ No _____
Explain ________________________________________

B. Is student under treatment for any medical or emotional condition? Yes _____ No _____
Explain ________________________________________

C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited __________ Limited __________
Explain ________________________________________

D. Is student physically and emotionally healthy? Yes _____ No _____
Explain ________________________________________

**Signature or Clinic Stamp REQUIRED:**

________________________________________

Signature of Physician/Physician Assistant/Nurse Practitioner Date of examination

________________________________________

Print Name of Physician/Physician Assistant/Nurse Practitioner Area Code/Phone Number

________________________________________

Office Address City State Zip Code