

CBU Student Health Form

THIS FORM MUST BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. IT MUST BE RETURNED TO:
Health Resources, Christian Brothers University • 650 East Parkway South, Box T-4 • Memphis, Tennessee 38104
Telephone 901-321-3260 / FAX 901-321-3524



Personal Information

Resident Commuter

Last Name _____ First _____ Middle Initial _____

SS# _____ Age _____ Sex _____ Date of Birth _____

THE PRE-ENTRANCE MEDICAL REPORT AND EXAMINATION ARE REQUIRED OF ALL STUDENTS entering Christian Brothers University. This record is to be filled out and signed by your personal physician. All information is strictly confidential and is obtained for the purpose of insuring adequate health care for the student in the event of illness or emergency. Also, if there are any reasons that the student cannot participate in regular university activities including physical education, they must be noted by the physician. We strongly recommend some type of health insurance so that proper and prompt treatment will be available if the need arises.

Data and History (Please answer each question)

Home Address _____

Date of University Entrance _____

Parent/Guardian Name _____

Parent/Guardian Home Address _____

Parent/Guardian Business Address _____

Home Telephone _____ Business Telephone _____

Health Insurance Company _____

Policy Number _____ Telephone _____

In Case of Emergency, Notify _____

Relation _____ Telephone _____

Treatment Authorization

I hereby authorize Christian Brothers University to gain professional medical treatment for the student here mentioned in the event of an emergency, until such time as the above listed person(s) can be notified.

Student's Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

PLEASE TURN OVER and Complete Other Side

Immunization Requirements

Td (Tetanus Diphtheria) / Date of Last Dose _____

MMR (Measles, Mumps, Rubella — 2 Doses Required) / Date of Last Dose _____

Polio / Date of Last Dose _____

Indicate Type OPV IPV

Tuberculin Skin Test / Date Within One Year of Admission to School

Test Date _____

Reading _____ mm

Physical Examination

DATE OF EXAM _____ HEIGHT _____ WEIGHT _____ BP _____ PULSE _____ TEMP _____

Indicate if normal / Describe if abnormal

Head _____ Abdomen (Hernia) _____

EENT _____ G.I. _____

Dental _____ GU _____

Neck _____ Musculoskeletal _____

Heart _____

Lungs _____

Hct _____ Blood Glucose _____ UA...Sp.Gr. _____ Albumin _____ Micro _____

Hx of Surgery, Hospitalization, or Chronic Illness

Describe and give dates _____

Medications Taken on a Regular Basis _____

Allergies to:

Medications / Other _____

Activity Exemption _____

Any condition / disability that would limit this student's physical activity _____

Physician's Signature _____

Physician's Name (Please Print or Type) _____

Professional Address _____

Office Telephone _____