ACCS Institution: _____

Medical History Form

This portion is to be completed by the student

Name _____ _____
Last First Middle SS#/ID

Home Address _____
Street City State Zip

_____ / / _____ _____
Cell Phone Date of Birth Male Female

_____ _____ _____
Emergency Contact Phone Relationship

This medical data is necessary to serve as a baseline for medical clearance for actual enrollment. Details of abnormalities should be recorded. Please check YES or NO to the following conditions.

CONDITIONS	NO	YES
Hypertension		
Rheumatic fever or heart trouble		
Liver trouble or jaundice (Hepatitis)		
Asthma or tuberculosis		
Major surgery or injury		
Ulcers or gastroenteritis		
Backache or joint trouble		
Kidney trouble		
Diabetes		
Severe headaches		
Epilepsy or convulsions		
Dyspnea		
Drug or alcohol problem		
Has applicant been treated for any emotional disorders?		
Has applicant, because of his/her health, withdrawn from college? If so explain		
Does the applicant have any illness or medical condition that requires regular treatment?		
Does the applicant miss school regularly or frequently due to any physical condition?		
Has the applicant been hospitalized?		
Any family member with chronic illness, mental or nervous disorders?		
Anemia		
Learning disability		

Comments: _____

Present Health: ____ Good ____ Fair ____ Poor Date of last exam: ____ / ____ / ____

Complete and return to:

ACCS Institution: _____

This portion is to be completed by a Physician.

Height _____ Weight _____ Skeletal Size: Small __ Medium __ Large __ EL __

B/P _____ Pulse _____ Respiration _____ Temperature _____

Laboratory Findings

Hemoglobin or Hematocrit _____ WBC _____ Serology _____

Urine: Sp.Gr _____ Alb _____ Sugar _____

Eyes					
Do you wear glasses?		No		Yes	
Do you wear contacts?		No		Yes	
Distant Vision	Without glasses				R20/
	With glasses				R20/
Near Vision	Without glasses				R20/
	With glasses				R20/

Ears				
Hearing normal?		No		Yes
Are drums intact?		No		Yes

Head, Neck and Face	Normal ( )	Abnormal ( )
Nose and Sinuses	Normal ( )	Abnormal ( )
Mouth and Throat	Normal ( )	Abnormal ( )
Teeth	Normal ( )	Abnormal ( )
Lungs and Chest	Normal ( )	Abnormal ( )
Heart	Normal ( )	Abnormal ( )
Vascular System	Normal ( )	Abnormal ( )
Abdomen	Normal ( )	Abnormal ( )
Endocrine System	Normal ( )	Abnormal ( )
Female: Breast	Normal ( )	Abnormal ( )
Female: Pelvic	Normal ( )	Abnormal ( )
Male: Genital	Normal ( )	Abnormal ( )
Male: Hernia	Normal ( )	Abnormal ( )

Present Health: ____ Good ____ Fair ____ Poor Date of exam: ____/____/____

I certify that the above information is true.

_____

Physician's Signature

Student's Signature

TO BE COMPLETED BY COLLEGE OFFICIAL

Date Received: [redacted]

Signature: [redacted]

Complete and return to:

ACCS Institution: _____

Immunization Form

To ensure the health and safety of our campus, immunizations against communicable disease is extremely important. Vaccination against Measles, Mumps, Rubella (MMR), Tetanus, and Meningococcal is required, as well as a negative Tuberculosis skin test. This is a requirement for all International Students. This form must be completed and submitted prior to admission in any ACCS institution.

Name _____
Last First Middle SS#/ID

Address _____
Street City State Zip

Date of Birth ___/___/___ Contact Number _____ Email _____

Section A: Required Immunizations/Tests				
			Month/Day/Year	Month/Day/Year
1. Meningitis Vaccine- within the last 5 years (Menomune, Menactra, Menveo)				
2. Measles, Mumps, Rubella (MMR)				
3. Tetanus				
4. Tuberculosis Screening				
TB Skin Test by PPD	Date Placed	Date Read	MM	Neg Pos
Chest X-Ray (if positive PPD or lab)	Date	Result	Submit copy of chest X-ray report	

Section B: Recommended Immunizations Please attach documentation of all childhood vaccinations (copy of Blue Card)				
	Month/Day/Year	Month/Day/Year	Month/Day/Year	Titer Date & Result
TD (Tetanus/Diphtheria)		Do not write here	Do not write here	Do not write here
AND/OR Tdap (Tetanus/Diphtheria)		Do not write here	Do not write here	Do not write here
Polio		Do not write here	Do not write here	
Hepatitis B				
Varicella (Chickenpox)			Do not write here	

I certify that the above dates and vaccinations are true.

_____
Signature of License Health Care Professional or Authorized Individual Date

Complete and return to: