



P.O. Box 370  
 Mars Hill, NC 28754  
 Admissions Phone: 828-689-1201  
 Toll Free: 866-642-4968 (866-MHC4YOU)  
 Infirmary Phone: 828-689-1243

<b>PHYSICAL EXAMINATION</b>		(Please print in black ink)		<b>To be completed and signed by physician or clinic</b>	
Last Name		First Name		Middle Name	
Permanent Address		City		State	
Date of Birth		Social Security Number		Zip Code	
Area Code/Phone		Vision: Corrected: Right 20/		Left 20/	
Uncorrected: Right 20/		Left 20/		Urinalysis: Glucose _____ Protein _____ Leukocytes _____	
Color Vision:		Hearing: (gross): Right		Left	
Hgb: _____ or Hct: _____					

Height \_\_\_\_\_ Weight \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Respirations \_\_\_\_\_ BP \_\_\_\_/\_\_\_\_

Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Mammary			

A. Is there loss or seriously impaired function of 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 \_\_\_\_\_

Additional comments: \_\_\_\_\_

Signature of Provider completing exam: \_\_\_\_\_ Date \_\_\_\_\_

Print Name of Provider, address and phone number OR office stamp: \_\_\_\_\_

<b>IMMUNIZATION RECORD</b> (Please print in black ink) <b>To be completed and signed by physician or clinic.</b> A complete immunization record from a physician or clinic may be attached to this form.				
Last Name	First Name	Middle Name	Date of Birth (mm/dd/yyyy)	Social Security Number

**SECTION A: REQUIRED IMMUNIZATIONS** These immunizations are required by North Carolina State Law. For further information, please visit the website <http://www.immunizenc.com/college.htm> OR contact the Director of Medical Services at Mars Hill College.

	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy
• DTP or Td (series of three required)				
• Tdap Booster (at least 1 within last 10 years)				
• Polio (series of three required)				
• MMR (series of 2 required after first birthday as a combination shot) OR...				
• Measles (after first birthday) <b>TWO DOSES REQUIRED</b>			Disease Date	Titer Date & Result
• Mumps <b>TWO DOSES REQUIRED</b>			Disease Date	Titer Date & Result
• Rubella <b>ONE DOSE REQUIRED</b>			Disease Date Not Accepted	Titer Date & Result
Hepatitis B (Series of 3 required if DOB is after July 1, 1994)				

• Tuberculin (PPD) Test (applied mm/dd/yyyy) (required within 12 months prior to the first day of classes)	Date read mm induration
Chest x-ray, if positive PPD	Date Results
Treatment, if applicable	Dates

The CDC recommends college students, especially freshmen living in dormitories, receive the meningococcal vaccine. Information concerning meningitis and immunization for this disease has been provided by the college. I choose decline the meningococcal vaccine. \_\_\_\_\_ (initial here to decline or place date in blank below indicating date vaccine was given)

	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy
Meningococcal			

**SECTION B: RECOMMENDED IMMUNIZATIONS**

The following immunizations are recommended for all students and may be required by certain departments (i.e. health sciences).

	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy
Varicella (chicken pox) series of two doses or immunity by positive blood titer		Disease Date	Titer Date & Result
Gardasil (series of 3)			
Other			

Signature or Clinic Stamp **REQUIRED**

Signature of Provider \_\_\_\_\_ Date \_\_\_\_\_  
 Print Name of Provider, Address, and Phone Number \_\_\_\_\_

**REPORT OF MEDICAL HISTORY** (Please print in black ink)

**To be completed by student**

Last Name (Please Print) \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Permanent Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Area Code/Phone Number \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_ Gender (circle one): Male Female Marital Status: M S Other

CLASS YOU ARE ENTERING (Circle one)  
Fr. So. Jr. Sr.

Previously enrolled here: Yes No  
If Yes, Dates \_\_\_\_\_

Semester Entering FALL SPRING  
SUMMER 1 SUMMER 2 YEAR 20\_\_

Health Insurance (Name and Address of Company) \_\_\_\_\_ Area Code/Phone Number \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Social Security Number \_\_\_\_\_ Employer \_\_\_\_\_

Policy or Certificate Number \_\_\_\_\_ Group Number \_\_\_\_\_

Is this an HMO/PPO/Managed Care Plan? Yes No

The following health history is confidential, does not affect your admission status and may only be shared with other health care professionals on an as needed basis to ensure that the student receives required and/or requested treatment and care as necessary. Please attach additional sheets for any items that require fuller explanation.

**FAMILY AND PERSONAL HEALTH HISTORY**  
completed by student

(Print in black ink)

To be

Has any person, related to you by blood, had any of the following?

	Yes	No	Relationship		Yes	No	Relationship		Yes	No	Relationship
High blood pressure				Cholesterol or blood fat disorder				Alcoholic/drug problems			
Stroke				Diabetes				Psychiatric illness			
Heart Attack before age 55				Glaucoma				Suicide			
Blood or clotting disorder				Cancer (type)				other			

Have you ever had or have you now: (please check at right of each item and if yes, indicated year of first occurrence)

	Yes	No	Year		Yes	No	Year		Yes	No	Year		Yes	No	Year
High blood pressure				Hay fever				Jaundice or hepatitis				Kidney stone			
Rheumatic fever				Allergy injection therapy				Rectal disease				Protein or blood in urine			
Heart trouble				Arthritis				Severe or recurrent abdominal pain				Hearing loss			
Pain or pressure in chest				Concussion				Hernia				Sinusitis			
Shortness of breath				Frequent/severe headaches				Easily fatigued				Severe menstrual cramps			
Asthma				Dizziness or fainting spells				Anemia or Sickle Cell Anemia				Irregular periods			
Pneumonia				Severe head injury				Eye trouble other than glasses/contact lenses				Sexually transmitted disease			
Chronic cough				Paralysis				Bone or joint deformity				Blood transfusion			
Head or neck radiation treatments				Disabling depression				Knee problems				Alcohol use			
Tumor or cancer (specify)				Excessive worry of anxiety				Recurrent back pain				Drug use			
Malaria				Ulcer				Neck injury				Anorexia/Bulimia			
Thyroid trouble				Intestinal trouble				Back injury				Smoke 1+ pack cigarettes/weekly			
Diabetes				Pilonidal cyst				Broken bone (specify)				Regular exercise			
Serious skin disease				Frequent vomiting				Kidney infection				Wear seat belt			
Mononucleosis				Gall bladder trouble or gallstones				Bladder infection				Other (specify)			

Please list any drugs, medicines, birth control pills, vitamins, and minerals (prescription and nonprescription) you use and indicate how often you use them.

Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_ Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_  
 Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_ Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_  
 Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_ Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_

**FAMILY AND PERSONAL HEALTH HISTORY-CONTINUED** (Please print in black ink) **To be completed by student**

Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on the right (or on an attached sheet).

Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

Adverse Reactions To:	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine			
Other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			
	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 physical or emotional problems? (explain)			
Is there loss or seriously impaired function of any organs? (Please describe)			
Other than for a routine check up, have you seen a physician or health-care professional in the past six months? (describe).			
Have you ever had any serious illnesses or injuries other than those already noted? (Specify when and where and give details.)			

**IMPORTANT INFORMATION ... PLEASE READ AND COMPLETE**

**STATEMENT BY STUDENT (OR PARENT/GUARDIAN IF STUDENT UNDER AGE 18)**

- A) 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.
- B) I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the physicians of the Student Health Service.
- C) I am aware that the Student Health Service charges for some services and I may be billed through the College Cashier if the account is not paid at the time of visit. I accept personal responsibility for settling the account with the Cashier and for payment of incurred charges. I am responsible for filing outpatient charges with insurance.

I also acknowledge that my responsibility to MHC is unaffected by the existence of insurance coverage.

Signature of Student \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent/Guardian, if student under age 18 \_\_\_\_\_ Date \_\_\_\_\_