Blinn College Health Science Programs

Please Check the appropriate program:

- ☐ ADN-HSC
- ☐ DENTAL-PO
- ☐ EMS-HSC
- ☐ FIRT-VM
- ☐ Vet Tech-VM
- ■ HITT-online
- ☐ PTA-HSC
- ☐ RAD TECH-HSC
- ☐ VOCN
  Brenham____
  Bryan____ -HSC

Brenham Campus, 902 College Ave., Brenham, TX 77833

Report of Medical History

Last Name	First	Middle	Maiden
Address – Number & Street	City	State	ZIP
Phone	Date of Birth	Blinn ID#	Sex

Emergency Notification

Person to notify in case of emergency

Last Name	First	Middle	
Address - Number & Street	City	State	ZIP
Home Phone	Work Phone	Pager	Relationship

Personal History

ANSWER ALL QUESTIONS. EXPLAIN "YES" ANSWERS BELOW:

HAVE YOU HAD?	YES	NO	HAVE YOU HAD?	YES	NO
Measles (rubeola)			Seizures		
Mumps			Dizziness, Fainting		
Rubella (German Measles)			Weakness, Paralysis		
Chicken Pox (varicella)			Joint Problems		
Diabetes			Back Problems		
Tuberculosis			Gastrointestinal Problems		
Hepatitis A/B/C			Heart Problems		
Visual Impairment			Malignancy		
Hearing Impairment			Respiratory Problems		
Surgery			Hernia		
Recurrent Headache			Allergies		
Any UNEXPLAINED weight loss (greater than 10 pounds)?					
Have you had any illness/injury or been hospitalized other than already noted?					
Is your ability to practice safe professional attributes adversely affected by a physical or mental disability/illness which may endanger the health and safety of persons?					

EXPLAIN "YES" ANSWERS, INCLUDING DATES OF DISEASE(S): _____

_____

_____

(Student) I verify that all of the above is true and complete to the best of my knowledge.

_____ Student Signature

_____ Date

NOTE: THIS PAGE OF FORM TO BE COMPLETED BY HEALTH CARE PROVIDER

Report of Health Evaluation

TO THE EXAMINING PHYSICIAN: Please review the student's history and complete the physician's form. Please comment on all positive answers. This information will be used only as a background for providing health care, if necessary.

Student Name			Blinn ID #
Blood Pressure	Height in inches	Weight in pounds	

ARE THERE ANY ABNORMALITIES OF THE FOLLOWING SYSTEMS?

SYSTEM	YES	NO	COMMENTS
Head/Ears/Nose/Throat			
Respiratory			
Cardiovascular			
Gastrointestinal			
Hernia			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			
Gynecological/OB			
Are there any speech/vision/hearing impairments?			
Eyes			Vision: Lt. Rt. Corrected: Yes No
Hearing			Hearing: Lt. Rt. Corrected: Yes No

In your opinion, is this individual in suitable physical and emotional condition for this Health Science Program: ☐ Unlimited ☐ Limited

Please explain: _____

_____

_____

_____ _____

Physician's Signature Date

_____ _____

Print Last Name First Phone (voice)

_____ _____

Address City State Zip Phone (fax)

The student is required to submit this completed form to the program director, before the start of their clinical hours.