



BISMARCK STATE COLLEGE MEDICAL EXAMINATION FORM

Student Name _____
Last First Middle

Program _____ Start Date _____

This form is required of all students admitted to
any of the following programs: Electrical Lineworker,
Welding and Surgical Technology.

PURPOSE OF EXAMINATION

- ▶ To promote early consultation for prevention and prompt care of disease and injury
- ▶ To indicate conditions for which a student should receive further consultation and/or treatment
- ▶ To provide information in case of emergency for a student subject to diabetes, allergies, convulsions, etc.
- ▶ To indicate conditions that may prevent a student from gaining employment in his/her chosen vocation

INSTRUCTIONS TO THE APPLICANT

This information is desired only as an aid in the consideration of your health. It will not affect your college standing.

1. Complete page two before having an examination by a licensed health care provider. Answer all questions and print clearly. This information will be treated confidentially and is for your own protection.
2. Make an appointment as soon as possible with the licensed health care provider of your choice. The examiner must sign the form on page three.
3. The medical examination is a post-admission requirement and is at your expense. Mail or fax the completed form to:

Bismarck State College
Student Records Office
P O Box 5587
Bismarck, ND 58506-5587
Fax (701) 224-5643

THE STUDENT:

Fill out this page before you see your examiner.

Date: _____

Name: _____
Last First Middle Date of Birth

Home Address: _____ Sex: F M
Street City State Zip

Person to be notified in case of an emergency: _____

Relationship: _____ Address: _____ Phone: _____

PERSONAL HISTORY

Have you ever lived in close personal contact with anyone who had tuberculosis? No Yes

If yes, explain: _____

Have you or do you now have any of the following? If none, check here

	Yes	No		Yes	No		Yes	No
1. Heart disease	_____	_____	4. Diabetes	_____	_____	7. Recurrent headaches	_____	_____
2. Tuberculosis	_____	_____	5. Hernia	_____	_____	8. Other	_____	_____
3. Asthma	_____	_____	6. Convulsions, blackouts, or nervous tendencies	_____	_____			

If yes, explain: _____

List dates of significant injuries or operations you have had. If none, check here

Injury/Operation	Date	Injury/Operation	Date
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any physical impairment such as paralysis, loss of vision, impaired hearing, back or spine conditions etc.? No Yes

If yes, explain: _____

Are you subject to any of the following? Yes No Yes No

1. Sensitivity to any medication such as penicillin, horse sera, etc.	_____	_____	3. Hay fever or asthma	_____	_____
2. Latex Sensitivity	_____	_____	4. Other sensitivity	_____	_____

If other, describe: _____

Have you ever had or are you now receiving treatment for any of the above? No Yes

If yes, explain: _____

Will you need treatment continued for any of these conditions while at school? No Yes

If yes, explain: _____

Are you taking any medication regularly? No Yes if yes, explain: _____

Have you ever been advised against normal physical exercise? No Yes if yes, give advisor, date, and reason:

MEDICAL EXAMINATION

Please review the personal and family history and make such examination as you deem necessary. We strongly urge that tetanus toxoid be given unless protected within the last 10 years. This examination is at the student's expense. We are happy to have your advice in the care of this student while at Bismarck State College.

Explain any conditions you consider significant in the family or personal history: _____

Complete all items, indicating normal by check mark or explaining positive findings.

Height: _____	Weight: _____	Blood Pressure: _____
Cardio-vascular _____	_____	_____
Lungs _____	_____	_____
Hernia _____	_____	_____
Ear, nose and throat _____	_____	_____
Vision _____	_____	_____
Color vision _____	Prescription of glasses if available R _____ L _____	_____
Hearing _____	_____	_____
Nervous system _____	_____	_____
Bone and joint _____	_____	_____

Are the following immunizations up to date?

Tetanus toxid _____	Polio _____
Varicella _____	Tuberculin _____
Measles and rubella _____	
Hepatitis B _____	Note: the above are strongly advocated.

Note allergies or sensitivities that may be significant. Normal _____

Explain any physical or emotional conditions you consider important. Normal _____

Is this student presently under medical therapy? No Yes If yes, explain:

Is this student capable of normal physical exercise, swimming or other athletic activity? No Yes if no, explain:

Comments concerning this individual regarding a career in surgical technology, welding, or lineworker:

Nurse Practitioner/Physicians Name (Print) _____ Signature _____ Date _____

Medical Facility _____ Street _____ City _____ State _____