

Arlington Baptist College

Name: _____ Age: _____ Gender: _____
Last First Middle

Address: _____
Street (Apt #) City State Zip

Business Phone: Father _____ Mother _____

Family Physician: _____
Name Address Phone

To Be Completed By Family Physician (Please answer all questions)

Medical History

Family:

Tuberculosis Diabetes Mental Illness

Personal:

Diabetes Rheumatic Fever
 Epilepsy Tuberculosis
 Heart Disease Typhoid Fever
 Asthma Poliomyelitis
 Ulcer (GI) Scarlet Fever
 Sinus Infection Small Pox
 Hay Fever Measles
 Frequent Headaches Rubella
 Venereal Disease Chicken Pox
 Mental Illness Mumps

Physical Examination

Date: _____

Height _____ Weight _____

Heart _____

Lungs _____

Hearing R _____ L _____

Vision _____

Immunization: (give dates)

TB Skin test _____ or Chest X-ray _____

Polio: Salk _____ Sabin _____

Tetanus (within four years) _____

Injuries or Operations (list and give dates) _____

Known Allergies (be specific) _____

Classification for Physical Activity:

Unlimited _____ No participation _____ Limited (explain) _____

Signature of examining Physician

DORM STUDENTS

To parents or Guardian: (please sign the following authorization)

1. In the event an ABC representative is unable to reach me by phone, I hereby authorize the representative to:

_____ Refer my child to the physician named on this certificate.

_____ Refer my child to the nearest medical facility.

2. I hereby consent to my child making any and all field trips in connection with his/her courses at ABC.

Date

Signature

Relationship to Student