

**ST. JOSEPH SEMINARY COLLEGE**  
**ST. BENEDICT, LOUISIANA 70457**  
**A CERTIFICATE OF HEALTH**

**TO BE FILLED OUT  
 COMPLETELY AND SIGNED  
 BY APPLICANT.**

Please return this form upon completion to the OFFICE OF STUDENT HEALTH no later than \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ General Health:  Good  Fair  Poor

PART I: CLINICAL HISTORY	YES	NO	EXPLAIN ANY ITEMS TO WHICH THE ANSWER IS YES, GIVING DATES AND RESULTS.
Have you ever been under treatment by a physician (or psychiatrist) for:			
1. Epilepsy, fits, convulsions, mental breakdown, emotional disorder or any other mental or nervous disorder.			
2. Any disease of the heart, high blood-pressure, dropsy, shortness of breath, varicose veins.			
3. Any disease of the lungs, including tuberculosis, pleurisy, pneumonia, bronchitis.			
4. Any disease of the stomach, intestines, gall bladder or other abdominal organ.			
5. Any disease of the kidneys or bladder including stone, pyelitis, cystitis.			
6. Any disease of the eyes, ears, mastoid, sinuses, tonsils, teeth, skin, glands.			
7. Rheumatism, arthritis, neuritis, or any disease of bones, joints or muscles.			
8. Anemi., hay fever, asthma, low blood pressure, diabetes.			
9. Have you had: a) A back injury b) Any other injury or deformity c) A hernia or rupture d) A surgical operation			
10. Have you ever been confined to a hospital or sanitarium?			
11. Have you withdrawn from grammar, high school or college for any length of time due to a 'nervous condition'?			
12. Have you had any diseases other than those listed?			
13. Immunization- a) Polio: How Many? _____ Date of last shot _____  b) Tetanus toxoid: Date _____ Required of all applicants within one year of entry. c) Smallpox vaccination: Date _____			
14. Do you have a sensitivity to any of the following: penicillin, sulfa, tetanus antitoxin, or any other drug or substance? If you do, please name _____			

I certify that the information given by me in answer to the above questions is correct to the best of my knowledge and recollection.

Date \_\_\_\_\_ 19\_\_\_\_ Signature of Student Applicant \_\_\_\_\_

**ST. JOSEPH SEMINARY COLLEGE**  
 ST. BENEDICT, LA. 70457  
**REPORT OF PHYSICAL EXAMINATION**

THIS PART TO BE COMPLETED  
 BY PHYSICIAN.

ALL ITEMS TO BE COMPLETED,  
 NO EXCEPTIONS, PLEASE

THE PHYSICIAN IS REQUESTED TO REVIEW THE DATA ON THE FRONT SIDE AND TO SUPPLY WHAT MAY HAVE ESCAPED THE APPLICANT'S KNOWLEDGE OR MEMORY.

Date \_\_\_\_\_ 19\_\_

I certify that I have carefully examined \_\_\_\_\_  
 who is signing this application for admission to St. Joseph Seminary College. I have found his condition to be as follows:

1. General appearance \_\_\_\_\_ 2. Age \_\_\_\_\_ 3. Height \_\_\_\_\_ 4. Weight \_\_\_\_\_  
 5. B. P. \_\_\_\_\_ 6. Pulse \_\_\_\_\_

**PHYSICAL EXAMINATION**

SYSTEM	NORMAL	ABNORMAL	LABORATORY
EENT			
Cardiovascular			1) Chest X-ray (mandatory)—Minifilm or other Date _____ Result _____
Pulmonary			
GI			2) Urinalysis
GU			Alb. _____ Sug. _____ Micro. _____
Neuromusculoskeletal			3) Other tests where indicated
Skin			
Psychiatric Status			

\*(If any abnormality noted, please type explanation below.)

Is the applicant presently under a physician's care? \_\_\_\_\_ If so, please type explanation below.

What prescriptive medicines is the applicant taking? \_\_\_\_\_  
 \_\_\_\_\_

Has the applicant been under the care of a psychiatrist or a psychologist within the last twelve months? \_\_\_\_\_  
 If so, please type explanation below.

Name and address of family physician \_\_\_\_\_

Name and address of examining physician (please type or print) \_\_\_\_\_

Signature of examining physician \_\_\_\_\_

Complete BOTH SIDES and return to the Office of Student Health.