ST. JOSEPH SEMINARY COLLEGE
ST. BENEDICT, LOUISIANA 70457

A CERTIFICATE OF HEALTH

TO BE FILLED OUT COMPLETELY AND SIGNED BY ENROLLEE.

Please return this form upon completion to the OFFICE OF STUDENT HEALTH no later than **the start of your first semester.**

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. Anemia , hay fever, asthma, low blood pressure, diabetes.			
9. Have you had: a) A back injury a b) Any other injury or deformity b c) A hernia or rupture c d) A surgical operation d			
10. Have you ever been committed 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 Have you withdrawn from grammar, high school or college for any length of time due to a 'nervous condition'?			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 students within one year or 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 _____ Signature of Enrollee _____

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

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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 ENROLLEE'S KNOWLEDGE OR MEMORY.

Date _____

I certify that I have carefully examined _____

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
EENT		
Cardiovascular		
Pulmonary		
GI		
GU		
Neuromusculoskeletal		
Skin		
Psychiatric Status		

LABORATORY

1) Chest X-ray (mandatory)—Minifilm or other Date _____

Result _____

2) Urinalysis
Alb. _____ Sug. _____ Micro. _____

3) Other tests where indicated

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

Is the enrollee presently under a physician's care? _____ If so, please type explanation below.

What prescriptive medicines is the enrollee taking? _____

Has the enrollee 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.