

Name <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:	
Address:				
City, State, Zip:		Social Security #:		
Emergency Contact:		Relationship to Student:		
Address:	Home Phone:			
City, State, Zip:	Alt. Phone:			
Health Insurance Co.:	Policy Number:			
Family Physician:	Physician Phone:			
Physician Address:	Date of last Physical Exam:			
Family Dentist:	Dentist Phone:			
Dentist Address:	Date of last Dental Exam:			

PERSONAL HEALTH HISTORY STATEMENT (to be completed by student)		
Medical Condition	Circle One	If yes, please explain:
Physical Disability	Yes No	
Learning Disability*	Yes No	
Physical Activity Restriction	Yes No	
Other	Yes No	

**Any diagnosed learning disability must be reported to the Academic Office with documentation. Necessary special arrangements will be made through that office.*

I agree that all information given is accurate to the best of my knowledge. Further, I give permission for the health care professional(s) listed above to release the required information to Ohio Christian University.

Signed: _____

Date: _____

Please return completed record to:

Ohio Christian University, Admissions Office, 1476 Lancaster Pike, Circleville, Ohio 43113

PROFESSIONAL HEALTH HISTORY STATEMENT (to be completed by health care professional)					
Medical Condition	Circle One		If yes, please explain:		
Heart Abnormality	Yes	No			
Vision Abnormality	Yes	No			
Disabilities or Handicaps	Yes	No			
Physical Activity Restriction	Yes	No			
Childhood illness:	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio				
Immunization	Series Dates				Last Vaccination Date
MMR (Measles, Mumps, Rubella)					
DTaP/DTP					
Varicella					
Hepatitis B					
Polio					
Influenza*					
Meningococcal**					
*Annual immunization recommended to avoid disruption of academic activities. **One dose recommended, preferably at entry into college, for freshmen living in residence halls to reduce their risk of meningococcal disease. Any graduate younger than 25 who wishes to reduce their risk of disease can consider the vaccine. Students with immunodeficiency such as complement deficiency or asplenia should receive the vaccine every 3-5 years.					
Immunization Notes (Please list any pertinent information related to vaccinations and/or reactions.)					
Tuberculosis Screening	Circle One		If yes, please explain		
Sign/Symptoms	Yes	No			
High Risk	Yes	No			
Skin Test Performed	Yes	No	Date:		Date Read:
			Result:		Interpretation: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
			Date:		Interpretation: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Chest X-Ray Required	Yes	No	Date:	Interpretation: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Additional Medical Consideration/Comments					
Healthcare Provider					
Name:				Phone:	

Signed:

Date:

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