



Huston-Tillotson University

Austin, Texas

Health Form

Health information obtained on this document is used by the Campus Nurse in order to provide the best possible medical care to all students. Information submitted is kept in strict confidence. **PLEASE TYPE OR PRINT LEGIBLY IN THE SPACE BELOW.**

Last Name

Middle Initial

First Name

Gender

M F

Parent's Telephone

Birth Date

 / /

E-Mail

Parent's Name

Parent's Address

Parent's City

State

Zip + 4

Your Height

 ()

Weight

 ()

Blood Pressure

 /

General Appearance

To be completed by medical personnel. Check all that apply.

	WNL	ABNORMAL (Describe)	ABNORMAL (Describe)		WNL
Skin and hair	_____			Throat	_____
Head	_____			Neck	_____
Eyes	_____			Heart	_____
External	_____			Rhythm	_____
Fundoscopic	_____			Sounds	_____
Ears	_____			Size	_____
External	_____			Abdomen	_____
Canal	_____			Genitalia	_____
Tympanic	_____			Extremities and	_____
Membranes	_____			Aerial Skeleton	_____
Hearing tests	_____			Structure	_____
Archery (<i>outdoor</i>)	_____			Strength	_____
Nose	_____			Range of motion	_____
Mouth	_____			Lymph nodes	_____
Tongue	_____			Neurological	_____
Teeth	_____			Reflexes	_____
Gums	_____			Coordination	_____
Chest	_____			Balance	_____
Appearance	_____			Motor	_____
Breath sounds	_____			Sensory	_____

Dipstick Urinalysis:

pH Protein Glucose Ketone
 Bilirubin Blood Nitrite Urobilinogen

This Admission form should be completed and returned to:

Campus Nurse
 Huston-Tillotson University
 900 Chicon Street
 Austin, TX
 78702-2795

Telephone:
512.505.3039

Toll Free:
1.877.487.8702

Fax:
512.505.3190

Other important Numbers

Main Telephone Number:
512.505.3000

Enrollment Management
512.505.3028

Financial Aid:
512.505.3031

Housing:
512.505.3157

Web site address:
www.htu.edu

Health Form

Comments and/or recommendations:

All admitted students are required to show proof of medical insurance, or they must purchase coverage from the University's carrier before completing the registration process.

Discussed examination with parent(s)/guardian? Yes No

Date

Physician's Signature

Athletes Only

If examination is for athletic participation, complete the following certificate:

I certify that on this date, I have examined the named student as indicated by the items checked and recommend him/her as being physically able to participate in supervised athletic activities as indicated below:

- | | | | | |
|--------------------------------------|-------------------------------------|--|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Baseball | <input type="checkbox"/> Basketball | <input type="checkbox"/> Cross Country | <input type="checkbox"/> Football | <input type="checkbox"/> Golf |
| <input type="checkbox"/> Gymnastics | <input type="checkbox"/> Soccer | <input type="checkbox"/> Swimming | <input type="checkbox"/> Volleyball | <input type="checkbox"/> Wrestling |
| <input type="checkbox"/> Other _____ | | | | |

Date

Signature of Examining Physician

Required Immunizations	Completed		Date of Last Injection
	Yes	No	
D.T. (State law requires one dose within past 10 years)			
TB skin test or check x-ray (within year)			
Polio			
Have you ever had the TB vaccine?			

All students born on or after January 1, 1957, must provide documentation of immunization against measles, mumps, and rubella.

MMR Vaccine Dose #1 _____ Dose #2 _____

Hepatitis B Vaccine Dose #1 _____ Dose #2 _____ Dose #3 _____