Allen Employee: ___ Yes ___ No

Term Admitted_____
(example: Summer 2024, Spring 2024, Fall 2025 etc.)

Allen College
UnityPoint Health

HEALTH RECORD

Student: _____ Birthdate: _____

Address: _____
Street City State Zip Code

PART I: COMPLETED BY STUDENT

HISTORY OF PAST OR PRESENT CONDITIONS, INJURIES, ILLNESS, AND SURGERY:
(+) Yes, give explanation below.

____ Allergies
____ Anemia
____ Back Injuries/Problems
____ Boils/Skin Infections
____ Cancer
____ Chicken Pox
____ Convulsions/Tremors
____ Diabetes
____ Dizziness
____ Epilepsy
____ Gastric Ulcer
____ Heart Trouble
____ Hepatitis A ___ B ____
____ Hernia
____ High Blood Pressure
____ Kidney Condition/Problem
____ Measles
____ Menstrual Problems
____ Mental Illness
____ Migraine Headaches
____ Mumps
____ Nervousness
____ Rheumatic Fever
____ Scarlet Fever
____ Skeletal Injury/Condition
____ Surgical Procedures (list below)
____ Tuberculosis
____ Positive TB Skin Test
____ Varicose Veins
____ Other Diseases/Health Problems Not Listed

EXPLANATIONS: _____

_____

_____

Have you lived or spent time overseas *(other than touring)*? If yes, where, when, and how long?

_____

_____

Current Medications *(please list dose and frequency)*:

_____

_____

Are you allergic to any medications? Please list medication(s) and describe your reactions or sensitivity.

_____

_____

CERTIFICATION

I, _____ (Student Signature), certify that the above statements are correct.

I, _____ (Student Signature), authorize the release of my medical information to Allen College.

TURN FORM OVER FOR PART II WHICH IS TO BE COMPLETED BY EXAMINER

UPLOAD THIS FORM TO CASTLEBRANCH ONCE COMPLETED

Student: _____ Birthdate: _____

PART II: COMPLETED BY EXAMINER

(Examiner may be a physician, employee health nurse, or adult nurse practitioner.)

PHYSICAL EXAM:

_____ **Height** _____ **Weight** _____ **T** _____ **P** _____ **R** _____**B/P**

_____ **Skin** **Ears:**___ *Normal* ____ *Impaired* ___ *Hearing Aid*

Eyes: *Vision* _____ *O.S* . ____ *O.D.* *Glasses/Contacts:* _____ *Yes* ____ *No*

Corrected Vision: ____ *O.S* . ____ *O.D.*

Throat, Tonsils, Thyroid: _____

Lungs: _____ **Heart:** _____

Breasts: _____ **Lymph Nodes:** _____

Abdomen: _____ **Hernia:** _____

Rectal: _____ **Nervous System:** *Reflexes* _____ ***Balance*** _____ ***Coordination*** _____ ***Gait*** _____

Known History of Mental Illness: _____

Menstrual History: _____ **Family History:** _____

SUMMARY: _____

RECORD OF *VOLUNTARY* IMMUNIZATIONS:

___/___/___ **Meningitis** Very Strongly Recommended for all students (especially those living in a dorm).
___/___/___ **Hepatitis A** Strongly Recommended for students going on missions/trips outside the U.S.

I certify that I have examined the person named and that the information is correct. In my judgment, the applicant
___ **IS** ___ **IS NOT** qualified regarding his/her health for enrollment in Allen College's health care program.

_____ _____ _____

Date *Examiner's Signature* *Credentials*

_____ _____

Printed Name *Address*