TOUGALOO COLLEGE

Owens Health and Wellness Center
Tougaloo, MS 39174
(601) 977-6160
(601) 977-4493 (Facsimile)

Dear Student:

The Staff of the Student Health Center welcomes you to Tougaloo College! We are here to help you stay healthier.

It is mandatory that the Health Center has a complete and current medical record on file for all students attending Tougaloo College. A complete medical record consists of the following:

1. A physical examination by a licensed physician on the enclosed Tougaloo College form.
   (***The physical must be done within the last year***.)
2. Proof of current immunization for Measles, Mumps, and Rubella (MMR)
3. Proof of Tetanus Booster.
   (***Issued within the last 10 years***.)
4. Proof of current TB (Tuberculin) Skin Test.
5. Meningitis Vaccine (*advised, but not required*)

You are required to have a physical examination prior to each academic year if a change occurs in your health status or if you plan to participate in any athletics at Tougaloo College. Athletic physicals cannot be substituted for the mandatory medical examination and will not be accepted.

All medical records are strictly confidential. All medical record contents should be returned to the Student Health Center before you register for classes. Please mail all information to:

Student Health Center
500 West County Line Road
Tougaloo, Mississippi 39174

Compliance with the above requested information is an important part of the registration process.
When you arrive for orientation, you will be issued a Health Center brochure that will help you to better understand the many services offered to you at Tougaloo College. However, if you have questions related to health services provided prior to your arrival, please call us at (601) 957-6776 or (601) 977-6160; it will be our pleasure to speak with you.

Sincerely,

Dr. Annyce Campbell

Dr. Annyce Campbell
College Doctor

TO BE COMPLETED BY STUDENT

TOUGALOO COLLEGE
Owens Health and Wellness Center
MEDICAL RECORD FORM

Last Name _____ First Name _____ Middle Name _____ Date of Birth _____

Social Security Number ___-___-___

Street Address _____ City _____ State _____ Zip _____

☐ Male ☐ Female U.S. Citizen: ☐ Yes ☐ No

☐ Married ☐ Single ☐ Widow (er) ☐ Divorced Religion _____

Parent, Guardian, or Spouse's Name _____ Area Code and Telephone Number _____

Street Address _____ City _____ State _____ Zip _____

HAVE YOU HAD OR DO YOU HAVE (PLEASE CHECK AT THE LEFT OF EACH ITEM):

Yes	No	* Infections Diseases*	Yes	No	* Cardiovascular Diseases*	Yes	No	* Metabolic/Endocrine Disorders*
☐	☐	AIDS/HIV Infection	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Frequent Conjunctivitis	☐	☐	Mitral Valve Prolapse	☐	☐	Obesity
☐	☐	Chicken Pox	☐	☐	Angina Pectoria	☐	☐	Goiter
☐	☐	Meningitis	☐	☐	Thrombophlebitis	☐	☐	Thyroid Disease
☐	☐	Infectious Mononucleosis						
☐	☐	Mumps						
☐	☐	Rheumatic Fever			* Hematologic Disorders*			* Urinary Track Disorders*
☐	☐	Whooping Cough	☐	☐	Anemia	☐	☐	Frequent Urinary Tract Infections
☐	☐	Measles/Rubella	☐	☐	Sickle Cell Disease	☐	☐	Kidney Stones
			☐	☐	Leukemia	☐	☐	Pyelonephritis
			☐	☐	Hemophilia			

		Respiratory Diseases			* Digestive System Disorders*			* Nervous System Disorders*
☐	☐	Bacterial Pneumonia	☐	☐	Gallbladder Disease	☐	☐	Epilepsy
☐	☐	Frequent Respiratory Infections	☐	☐	Ulcerative Colitis	☐	☐	Frequent Headaches
☐	☐	Chronic Frequent Colds	☐	☐	Crohn's Disease	☐	☐	Glaucoma
☐	☐	Asthma	☐	☐	Frequent Indigestion	☐	☐	Dizziness/Fainting Spells
☐	☐	Sinusitis	☐	☐	Irritable Bowel Syndrome	☐	☐	Hayfever
☐	☐	Tuberculosis	☐	☐	Hemorrhoids	☐	☐	Allergies (Food, Medicine)
			☐	☐	Gastritis	☐	☐	Sleep Disorders
			☐	☐	Hepatitis/ Jaundice	☐	☐	Alcohol/ Drug Addiction
			☐	☐	Peptic Ulcer Disease	☐	☐	Visual Problems

If yes, Describe _____

*** Are you allergic to any medicine?** Please list: _____

☐Yes ☐No Do you wear glasses?

☐Yes ☐No Do you sleep walk?

☐Yes ☐No Do you have dental cavities?

☐Yes ☐No Do you live with anyone who has Tuberculosis?

☐Yes ☐No Are you taking medications for TB?

☐Yes ☐No Have you ever taken medications for TB?

☐Yes ☐No Are there any other health conditions for which you were under a doctor's care?

If yes, Explain: _____

☐Yes ☐No Have you ever consulted or been treated by a psychiatrist? If yes, list the name and address of the doctor.

_____

☐Yes ☐No Have you ever been a patient in a mental hospital or sanitarium?

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.

Signature _____ Date _____

(601) 977-6160
Fax (601) 977-4493

TO BE COMPLETED BY STUDENT

Medical Record Attachment

1. Do you have any Allergies? Please List._____

   If yes, what medicine(s) do you take? _____

2. Have you ever been told that you have diabetes (sugar)? Yes No

3. Have you ever been told that you have hypertension (high blood pressure)? Yes No

   If yes, what medicine do you take for it? _____

4. Have your been told that you have Sickle Cell Anemia? Yes No

5. Do you wear a BRACE on you shoe, knee, back, etc? Yes No

6. Have you ever had seizures? Yes No

   If yes, what medicine do you take for it? _____

7. What medicine(s) do you take that require a prescription?

   _____

8. What medicine(s) do you take that do not require a prescription?

   _____

9. Have you ever had surgery? Please list type and dates of surgery.

   _____

"WHERE HISTORY MEETS THE FUTURE"

TO BE COMPLETED
BY PHYSICIAN

PLEASE PRINT

Patient Last Name _____ First Name _____ Middle Name _____

PHYSICAL EXAMINATION TO BE COMPLETED BY A PHYSICIAN

Height _____ Weight _____ Build: ☐ Slender ☐ Medium ☐ Heavy ☐ Obese

Blood Pressure: Sys: _____ Pulse: A. Sitting _____

Dias: _____ B. Standing _____

T.B. Skin Test _____

CLINICAL EXAMINATION
(PLEASE CHECK EACH ITEM IN THE APPROPRIATE COLUMN)
"NE" IF NOT EVALUATED

NE	NORMAL	ABNORMAL		NE	NORMAL	ABNORMAL	
☐	☐	☐	Head, Face, Neck Scalp	☐	☐	☐	Nose
☐	☐	☐	Sinuses	☐	☐	☐	Mouth and Throat
☐	☐	☐	Ears-General	☐	☐	☐	Tympanic Membrane (Perforation)
☐	☐	☐	Eyes-General	☐	☐	☐	Ophthalmoscopic
☐	☐	☐	Pupils (Equally and Reaction)	☐	☐	☐	Ocular Mobility (Associated parallel movement nystagmus)
☐	☐	☐	Lungs and Chest (Include breasts)	☐	☐	☐	Vascular System (Varicosities, etc.)
☐	☐	☐	Heart (Throat, size rhythm, sounds)	☐	☐	☐	Anus and Rectum (Hemorrhoids, fistula)(Prostate, if indicated)
☐	☐	☐	Abdomen and Viscera (include hernia)	☐	☐	☐	Upper Extremities(Strength, range, of motion)
☐	☐	☐	Endocrine System	☐	☐	☐	Spine, Other Musculoskeletal
☐	☐	☐	G-U System	☐	☐	☐	Skin, Lymphatic
☐	☐	☐	Feet	☐	☐	☐	Psychiatric (Specify any personality disorder)
☐	☐	☐	Lower Extremities	☐	☐	☐	Identifying Body Marks, Scars, Tattoos
☐	☐	☐	Neurologic	☐	☐	☐	Neurologic
☐	☐	☐	Pelvic (Female Only) If Indicated ☐ Vaginal ☐ Rectal				

Yes ☐ No ☐ Does patient take any medication such as insulin, thyroid, dilantin , phenobarbital, tranquilizers, digitalis, reducing pills, vitamins, allergy shots or medications, liver shots, iron, penicillin, sulfa, cortisone, pain or other medications regularly? If so, list below by name and frequency.

_____

_____

Yes ☐ No ☐ Is there any reason why this student cannot participate in physical education?

Yes ☐ No ☐ Is there any reason why this student should not live in the dormitory if they so desire?

_____ Examining Physician's Signature

_____ Date

_____ Examining Physician's Typed or Printed Name

_____ Address

_____ Phone Number