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. Annynce Campbell**
Dr. Annynce Campbell
College Doctor
TOUGALOO COLLEGE
Owens Health and Wellness Center
MEDICAL RECORD FORM

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Social Security Number

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Parent, Guardian, or Spouse's Name

Area Code and Telephone Number

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Infections Diseases*</th>
<th>Cardiovascular Diseases*</th>
<th>Metabolic/Endocrine Disorders*</th>
<th>Urinary Track Disorders*</th>
<th>Hematologic Disorders*</th>
<th>Nervous System Disorders*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>AIDS/HIV Infection</td>
<td>High Blood Pressure</td>
<td>Diabetes</td>
<td>Frequent Urinary Tract Infections</td>
<td>Anemia</td>
<td>Epilepsy</td>
</tr>
<tr>
<td>Frequent Conjunctivitis</td>
<td>Mural Valve Prolapse</td>
<td>Obesity</td>
<td></td>
<td>Sickle Cell Disease</td>
<td>Frequent Headaches</td>
</tr>
<tr>
<td>Chicken Pox</td>
<td>Angina Pectoris</td>
<td>Osteoporosis</td>
<td></td>
<td>Leukemia</td>
<td>Glaucoma</td>
</tr>
<tr>
<td>Meningitis</td>
<td>Thrombophlebitis</td>
<td>Thyroid Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infectious Mononucleosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatic Fever</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whooping Cough</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles/Rubella</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

*Respiratory Diseases* | Digestive System Disorders* | | |
|----------------------|--------------------------| | |
| Yes | No | Yes | No | | |
| Bacterial Pneumonia | Gallbladder Disease | | | |
| Frequent Respiratory Infections | Ulcerative Colitis | | | |
| Chronic Frequent Colds | Crohn's Disease | | | |
| Sinusitis | Frequent Indigestion | | | |
| Tuberculosis | Irritable Bowel Syndrome | | | |
| | Hemorrhoids | | | |
| | Gastritis | | | |
| | Hepatitis | Jaundice | | | |
| | Peptic Ulcer Disease | | | |

* Are you allergic to any medicine? Please list:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you wear glasses?</td>
<td></td>
</tr>
<tr>
<td>Do you have dental cavities?</td>
<td></td>
</tr>
<tr>
<td>Are there any other health conditions for which you were under a doctor's care?</td>
<td></td>
</tr>
</tbody>
</table>

If yes, Explain:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever consulted or been treated by a psychiatrist? If yes, list the name and address of the doctor.</td>
<td></td>
</tr>
<tr>
<td>Have you ever been a patient in a mental hospital or sanitarium?</td>
<td></td>
</tr>
</tbody>
</table>

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
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 you 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"
Patient Last Name

First Name

Middle Name

PHYSICAL EXAMINATION TO BE COMPLETED BY A PHYSICIAN

Height: 

Weight: 

Build: □ Stender □ Medium □ Heavy □ Obese

Blood Pressure: Sy: 

Di: 

Pulse: 

A. Sitting: 

B. Standing: 

T.B. Skin Test: 

CLINICAL EXAMINATION

(PLEASE CHECK EACH ITEM IN THE APPROPRIATE COLUMN)

“NE” IF NOT EVALUATED

NE

NORMAL

ABNORMAL

Head, Face, Neck Scalp □

Sinuses □

Ears-General □

Pupils (Equality and Reaction) □

Lungs and Chest (Include breasts) □

Heart (Throat, size rhythm, sounds) □

Abdomen and Viscera (include hernia) □

Endocrine System □

G-U System □

Feet □

Lower Extremities □

Neurologic □

Pelvic (Female Only) □

If indicated □ Vaginal □ Rectal □

NE

NORMAL

ABNORMAL

Nose □

Mouth and Throat □

Tympanic Membrane (Perforation) □

Ophthalmoscopic □

Ocular Mobility (Associated parallel movement nystagmus) □

Vascular System (Varicosities, etc.) □

Anus and Rectum (Hemorrhoids, fistula, Prostate, if indicated) □

Upper Extremities(Strenght, range, of motion) □

Spine, Other Musculoskeletal □

Skin, Lymphatic □

Psychiatric (Specify any personality disorder) □

Identifying Body Marks, Scars, Tattoos □

Neurologic □

Yes □ No □ Does patient take any medication such as insulin, thyroid, dilantin, phenobarbital, tranquilizers, digoxis, reducing pills, vitamins, allergy shots or medications, liver shots, iron, penicillin, sulf, 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?

Examing Physician's Signature

Date

Examing Physician's Typed or Printed Name

Address

Phone Number