TENNESSEE STATE UNIVERSITY BAND
STUDENT HEALTH FORM

Name _____ Social Security No. _____
Last First Middle

Date of Birth _____ Sex _____ Marital Status _____

Home Address _____
Street City State Zip Code

Parent or Guardian _____ Phone _____

1. Do you have hospitalization? _____ Company and policy number _____

   If you do not have insurance we strongly recommend that you obtain school insurance.
   Rate will be available during registration.

2. Have you ever had?

| | Yes | No | Immunizations | Yes | No | Date |
|---|---|---|---|---|---|---|
| Measles | _____ | _____ | Tetanus | _____ | _____ | _____ |
| Chicken Pox | _____ | _____ | Polio | _____ | _____ | _____ |
| Whooping Cough | _____ | _____ | Measles | _____ | _____ | _____ |
| Polio | _____ | _____ | Mumps | _____ | _____ | _____ |
| Mumps | _____ | _____ | Whooping Cough | _____ | _____ | _____ |
| Hepatitis | _____ | _____ | Diptheria | _____ | _____ | _____ |

3. Have you had surgery? _____ List surgery and date. _____

4. Have you been treated for any serious medical illness (hypertension, diabetes, asthma, epilepsy, sickle cell anemia)? _____ Give details. _____

5. Are you presently on any medication? _____ If so, list medication(s). _____

   _____

6. Do you have any allergies? _____

7. Have you ever been treated for any mental problems? _____

8. Is there a family history of a bleeding disorder, cancer, hypertension or diabetes? _____
   List and relationship. _____

If a student is under 18 years of age we need permission to treat the student or hospitalize for a serious illness at the discretion of a Student Health Physician.

Date _____ Signature of Applicant _____

Physician Signature _____ Parent of Guardian _____

**Health examination form must be completed by a physician, nurse practitioner or a licensed physician's assistant.**

Age _____ Height _____ Weight _____

1. Blood Pressure _____

2. Pulse Rate _____ Character _____

| | Normal | Abnormal | Comments |
|---|---|---|---|
| 3. Eyes | _____ | _____ | _____ |
| 4. Ears | _____ | _____ | _____ |
| 5. Nose and throat | _____ | _____ | _____ |
| 6. Sinuses | _____ | _____ | _____ |
| 7. Mouth and teeth | _____ | _____ | _____ |
| 8. Chest | _____ | _____ | _____ |
| 9. Heart | _____ | _____ | _____ |
| 10. Abdominal Viscera | _____ | _____ | _____ |
| 11. Endocrine Viscera | _____ | _____ | _____ |
| 12. Nervous system | _____ | _____ | _____ |
| 13. Lymphatic glands | _____ | _____ | _____ |
| 14. Orthopedic defects | _____ | _____ | _____ |

Laboratory Date:

Urinalysis: Albumen _____ Sugar _____ Blood _____

Hematocrit: _____

Is there any condition that would prevent this student from participating in physical activities.
Yes_____ No_____ If yes please explain_____

_____

Physician Signature: _____

We recommend a tetanus booster if you have not had one in the last five years.

We recommend a tuberculin skin test if none has been done in the last 12 months.

***MUST BE SIGNED AND STAMPED BY PHYSICIAN OR HEALTH DEPARTMENT PROVIDING THE PHYSICAL EXAM.**