Southwestern Christian College
200 Bowser Circle
Terrell, TX 75160
"Large Enough to Matter, Small Enough to Care"

Student Medical Record

The Southwestern Christian College Admissions Department requires each applicant to complete a medical history form and have a physical examination done (If the applicant has had a physical examination done within the last two years, please submit a copy of that exam).

Applicant Information

Name: _____
(Last Name) (First Name) (Middle Initial) (Suffix: Jr. etc.)

Address: _____ Apt #: _____

City: _____ State: _____ County: _____ Zip Code: _____
(for Texas residence only)

Phone Number: _____ E-Mail Address: _____

Would you like to receive text messages? ☐ Yes ☐ No Date of Birth: ___/___/_____ GENDER: ☐ Male ☐ Female

Parent/Guardian Information

Name: _____ Phone: _____

Address: _____ Apt #: _____

City: _____ State: _____ County: _____ Zip Code: _____
(for Texas residence only)

Family Physician Information

Name: _____ Phone: _____

Address: _____ Apt #: _____

City: _____ State: _____ County: _____ Zip Code: _____
(for Texas residence only)

Applicant's Medical Background Information

1. Do you presently have any allergies? ☐ Yes ☐ No If yes, please specify: _____
2. Are you presently under a doctor's care? ☐ Yes ☐ No If yes, please explain: _____
3. Are you taking any prescription medications? ☐ Yes ☐ No If yes, please list: _____
4. Do you have any medical conditions? ☐ Yes ☐ No If yes, please list and explain: _____

Health Records are held in strict confidence as with all other materials submitted to Southwestern Christian College. The applicant is to sign below stating that s/he has read this statement and thereby authorizes SwCC administration to release necessary health information in emergency or life-threatening situations. (If applicant is under the age of 18, then his/her parents or guardians need to co-sign).

_____ _____ _____
Applicant's Signature Parent/Guardian's Signature (if applicant is under 18) Date

Physical Examination (To Be Completed By the Physician)

Student Name: _____

Height: _____ Weight: _____ Blood Pressure: _____

Heart and Rhythm of Pulse: _____

Skin: _____ Ears: _____

Eyes: _____ Right: 20/_____ Left: 20/_____

Nose: _____ Sinuses: _____

Teeth: _____ Throat (Tonsils): _____

Lungs and Chest: _____ Breasts: _____

Blood Sugar: _____ Urine (Protein): _____

Any weaknesses, handicaps or physical limitations? ☐Yes ☐No

If yes, please list and explain: _____

Do you consider the applicant's health adequate for intensive schoolwork and activities? ☐Yes ☐No

Remarks/Recommendations:

_____

_____

Immunization Records (To Be Completed By the Physician)

Vaccine	Date	Date	Date	Date	Date
DTP					
TD or Tetanus					
HepA-HepB					
Pneumococcal					
TBC Test					
MMR, MMRV					
Polio					
Varicella					
Meningococcal (MCV4)					

_____ _____

Physician's Signature Date