

Name: _____
(PLEASE PRINT) LAST FIRST MIDDLE

Country of Birth: _____ Country of Citizenship: _____

☐ **PART A. MEDICAL HISTORY: (TO BE COMPLETED BY STUDENT APPLICANT)**

Have you had or do you now have any of the following conditions? If yes, provide approximate dates:

- | | | | | | |
|---|---|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> COVID-19 Vaccination Completed (Attach Proof to Application) |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Intestinal Problems | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Stomach Ulcer | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Other Conditions (including but not limited to learning disabilities): | |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Heart Problem (restrictions) | <input type="checkbox"/> Malaria | <input type="checkbox"/> Rheumatic Fever | | |
| <input type="checkbox"/> Blackouts | | <input type="checkbox"/> Measles (Rubeola) | <input type="checkbox"/> Rubella | | |

Any complications/restrictions due to the above conditions?: ☐ NO ☐ YES. Explain below: _____

Do you have any conditions that would affect your ability to enroll in a full time course load of study? ☐ NO ☐ YES. Please list conditions and limitations: _____

Give dates and types of serious operations or injuries: _____

I understand that falsification or withholding of information on the Health Examination Report shall constitute grounds for denial of my application.

Applicant Signature: _____ **Date:** _____

☐ **PART B. MEDICAL CERTIFICATION (TO BE COMPLETED BY PRIMARY CARE PROVIDER- PCP)**

Current immunizations and tuberculosis clearance with dates specified must be completed and verified by a qualified physician before acceptance to San Diego Mesa College.

1. Tetanus (must be within the past nine years) Date: _____
2. Measles (rubeola), Mumps, Rubella (must be given after 1970 and after 12 months of age)
Measles (rubeola) Date: _____ Mumps Date: _____ Rubella Date: _____
3. Polio Date: _____
4. BCG Inoculation Date: _____

If no BCG documentation, Tuberculosis Clearance, dated within the past three months of the physical exam, complete one of the following:

QuantiferON blood test Date: _____ Result: _____

Mantoux skin test Date: _____ Result*: _____

*If Mantoux test is positive, chest x-ray is required

Chest X-Ray Date: _____ Result*: _____

*Attach copy of your chest x-ray report. Do not send the x-ray film

Does student have any conditions which would affect the student's ability to perform in an academic setting?

☐ NO ☐ YES, Explain: _____

Special Health Problems, including conditions that would limit full-time study: _____

I have examined _____ and find him/her in good health and able to attend college.

STUDENT NAME

Signature of PCP: _____ Date: _____

Name of PCP: _____ (PLEASE PRINT)

Address: _____

E-mail: _____

Phone Number: _____ **PCP Stamp or Business Card →**

