HEBREW UNION COLLEGE – JEWISH INSTITUTE OF RELIGION
היברו יוניון קולג - מכון למדעי היהדות

MEDICAL FORM – Part 2

(To be completed by the *Physician*)

INSTRUCTIONS: Please complete "Physical Examination" and "Immunization" sections and return form by mail or scanned email to:

Hebrew Union College-Jewish Institute of Religion
National Office Recruitment and Admissions
3101 Clifton Avenue
Cincinnati, OH 45220-2488
admissions@huc.edu

PHYSICAL EXAMINATION

STUDENT'S NAME ______________________________ Date ____________
(Print) Last First Middle

1. GENDER _____ HEIGHT _________ BUILD: SLENDER ________ HEAVY ______ BLOOD PRESSURE ________
AGE _____ WEIGHT _________ MEDIUM ________ OBESE ______ PULSE ________

2. VISION: WITH GLASSES: HEARING:
RIGHT 20/ ________ RIGHT 20/ ________ COLOR VISION ________________ RIGHT ______/15
LEFT 20/ ________ LEFT 20/ ________ TEST USED ________________ LEFT ______/15

IF CORRECTION IS NEEDED, PLEASE REFER IMMEDIATELY.

IMMUNIZATION

IT IS REQUIRED THAT ALL INCOMING STUDENTS BE IMMUNIZED AGAINST MEASLES, MUMPS, AND RUBELLA (MMR). PERSONS BORN PRIOR TO JANUARY 1, 1957 ARE EXEMPT FROM THIS REQUIREMENT.

MUMPS

Date of Illness __________ or
Date of Immunization __________ or
Date of Antibody Titer __________ Results __________

MEASLES

Date of Illness __________ or
Date of Immunization, #1__________ #2 __________
Date of Antibody Titer __________ Results __________
(Both must be after 1968; #1 must be 12 months from birth or later and #2 must be at least one month from the first)

RUBELLA

Date of Immunization __________ or
Date of Antibody Titer __________ Results __________
(Diagnosis of the disease is not acceptable)

M.M.R. (MEASLES, MUMPS AND RUBELLA)

Date of 1st Immunization __________
(must be 12 months after birth or later but before five years of age)

Date of 2nd Immunization __________
(must be at lease one month from the first)

CLINICAL EVALUATION

CHECK EACH ITEM IN PROPER COLUMN. ENTER "NE" IF NOT EVALUATED.	NORMAL	ABNORMAL	NOTE: GIVE DETAILS OF EACH ABNORMALITY. ENTER CORRESPONDING ITEM NUMBER BEFORE EACH COMMENT.
3. HEAD, NECK, FACE, AND SCALP			
4. NOSE AND SINUSES			
5. MOUTH, TEETH, GINGIVA, AND THROAT			
6. EARS -- GENERAL (CANALS, DRUMS, ETC.)			
7. EYES -- GENERAL (LIDS, PUPILS, MOTIONS, ETC.)			
8. LUNGS, CHEST, AND BREASTS			
9. HEART (INCLUDES ESTIMATE OF CARDIA FUNCTION)			
10. VASCULAR SYSTEM (INCLUDE VARICOSITIES)			
11 ABDOMEN AND VISCERA (INCLUDE HERNIA)			
12. ANO-RECTAL AND PILONIDAL			
13. ENDOCRINE SYSTEM			
14. GENITO-URINARY SYSTEM			
15. UPPER EXTREMITIES			
16. LOWER EXTREMITIES (INCLUDE FEET)			
17. SPINE, OTHER MUSCULOSKELETAL			
18. SKIN AND LYMPHATIC (INCLUDE ACNE)			
19. NEUROLOGICAL SYSTEM			
20. PSYCHIATRIC (SPECIFY ANY PERSONALITY DEVIATION)			

21. If female, please note any gynecologic problems ______________________________

22. Urinalysis: Albumin__________ Sugar_________ Special tests used in clinical evaluation (blood, EKG, etc)______________________________

23. **If necessary**, Report and Date of recent chest x-ray ______________________________

24. Consultation used or indicated (dental, oculist, etc.) ______________________________

25. Any drug allergies ______________________________

26. Is this individual capable of normal physical activity? (Athletics, hiking, rugged travel?) ______________________________

If not, give reasons and limitations. ______________________________

27. Do you consider the student's health to be such that it would allow him or her to stand the rigors of an academic course of study? ____________________

COMMENTS: ______________________________

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Student's Last Name: