BISMARCK STATE COLLEGE
MEDICAL EXAMINATION FORM
Electrical Lineworker

Name: ____ ________________
Last First Middle Date of Birth

Home Address: ____Sex: F ☐ M ☐
Street City State Zip

Person to be notified in case of an emergency: ____

Relationship: _________________ Address: ____ Phone: ______________________

PURPOSE OF EXAMINATION

- To promote early consultation for prevention and prompt care of disease and injury
- To indicate conditions for which a student should receive further consultation and/or treatment
- To provide information in case of emergency for a student subject to diabetes, allergies, convulsions, etc.
- To indicate conditions that may prevent a student from gaining employment in his/her chosen vocation

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INSTRUCTIONS:

This information is desired only as an aid in the consideration of your health.
It will not affect your college standing.

1. The medical examination is a post-admission requirement and is at the student's expense.
2. Please make an appointment with a licensed Nurse Practitioner/Physician of your choice**.**
3. The student completes pages 1 and 2.
4. The examiner must complete and sign page 3.
5. Mail or fax the completed form to:

Bismarck State College
Academic Records Office
P O Box 5587
Bismarck, ND 58506-5587
Fax (701) 224-5643

PERSONAL HISTORY

Have you ever lived in close personal contact with anyone who had tuberculosis? No ☐ Yes ☐

If yes, explain: ____

Have you or do you now have any of the following? If none, check here ☐

	Yes	No		Yes	No		Yes	No
1. Heart disease	______	______	4. Diabetes	______	______	7. Recurrent headaches	______	______
2. Tuberculosis	______	______	5. Hernia	______	______	8. Other	______	______
3. Asthma	______	______	6. Convulsions, blackouts, or nervous tendencies	______	______			

If yes, explain: ____

List dates of significant injuries or operations you have had. If none, check here ☐

Injury/Operation	Date	Injury/Operation	Date

Do you have any physical impairment such as paralysis, loss of vision, impaired hearing, back or spine conditions etc.? No ☐ Yes ☐

If yes, explain: ____

Are you subject to any of the following?

	Yes	No		Yes	No
1. Sensitivity to any medication such as penicillin, horse sera, etc.	_____	_____	3. Hay fever or asthma	_____	_____
2. Latex Sensitivity	_____	_____	4. Other sensitivity	_____	_____

If other, describe: ____

Have you ever had or are you now receiving treatment for any of the above? No ☐ Yes ☐

If yes, explain: ____

Will you need treatment continued for any of these conditions while at school? No ☐ Yes ☐

If yes, explain: ____

Are you taking any medication regularly? No ☐ Yes ☐ if yes, explain: ______________________________

Have you ever been advised against normal physical exercise? No ☐ Yes ☐ if yes, give advisor, date, and reason:

____

____

MEDICAL EXAMINATION

Please review the personal and family history and make such examination as you deem necessary. We strongly urge that tetanus toxoid be given unless protected within the last 10 years. This examination is at the student's expense. We are happy to have your advice in the care of this student while at Bismarck State College.

Explain any conditions you consider significant in the family or personal history: ____________________________________

____

Complete all items, indicating normal by check mark or explaining positive findings.

Height: _________ Weight: _________ Blood Pressure: _______________

Blood Sugar Level:____________

Cardio-vascular _________ ____
Lungs _________ ____
Hernia _________ ____
Ear, nose and throat _________ ____
Vision _________ ____
Color vision Prescription of glasses if available R _______________ L _________________
Hearing _________ ____
Nervous system _________ ____
Bone and joint _________ ____

Are the following immunizations up to date?

Tetanus toxid ____________________ Polio ____________________
Varicella ____________________ Tuberculin ____________________

Measles and rubella ____________________
Hepatitis B ____________________ Note: the above are strongly advocated.

Note allergies or sensitivities that may be significant. Normal ☐ ________________________________

____

Explain any physical or emotional conditions you consider important. Normal ☐ ______________________

____

Is this student presently under medical therapy? No ☐ Yes ☐ If yes, explain:

____

____

Is this student capable of normal physical exercise, swimming or other athletic activity? No ☐ Yes ☐ if no, explain:

____

____

Comments concerning this individual regarding a career in the lineworker program:

____

____

____

____

Nurse Practitioner/Physicians Name (Print) Signature Date

____

Medical Facility:________________ Street ________________ City ________ State_______