BISMARCK STATE COLLEGE | North Dakota's Polytechnic Institution

MEDICAL EXAMINATION FORM
Electrical Lineworker

Name: _____ _____
Last First Middle Date of Birth

Home Address: _____ Sex: F ☐ M ☐
Street City State Zip

Driver's License Number: _____

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 with diabetes, allergies, convulsions, etc.
- To indicate conditions that may prevent a student from gaining employment in his/her chosen vocation

INSTRUCTIONS:

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

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, fax, or email all three pages of the completed form to:

Bismarck State College
MACC Office c/o Mark Voigt
P O Box 5587
Bismarck, ND 58506-5587
Fax (701) 224-2507
mark.voigt@bismarckstate.edu

PERSONAL HISTORY

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. Hernia	____	____	6. Recurrent headaches	____	____
2. Asthma	____	____	5. Convulsions, blackouts,			7. Other	____	____
3. Diabetes	____	____	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.? Yes ☐ No ☐

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? Yes ☐ No ☐

If yes, explain: _____

Will you require ongoing treatment for any of these conditions while attending school? Yes ☐ No ☐

If yes, explain: _____

Are you taking any medication regularly? Yes ☐ No ☐

If yes, explain: _____

Have you ever been advised against normal physical exercise? Yes ☐ NO ☐

If yes, give advisor, date, and reason: _____

_____

MEDICAL EXAMINATION

Please review the personal and family history and conduct any necessary examination. We strongly recommend administering tetanus toxoid unless protection has been received within the last 10 years. This examination is at the student's expense. We appreciate your guidance in caring for this student during their time 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: _____

Cardio-vascular: _____ _____

Lungs: _____ _____

Hernia: _____ _____

Ear, nose, 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: _____ Varicella: _____ Polio: _____ MMR: _____ Hepatitis B: _____

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? Yes ☐ No ☐

If yes, explain: _____

_____

Is this student capable of engaging in normal physical exercise, such as climbing or other athletic activities?

Yes ☐ No ☐

If no, explain: _____

_____

Comments concerning this individual regarding a career in the Lineworker Program:

_____

_____

_____

Nurse Practitioner/Physician's Name (Print) **Signature** **Date**

Medical Facility: **Street** **City** **State**