



**BISMARCK**  
STATE COLLEGE

North Dakota's  
Polytechnic Institution

**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: \_\_\_\_\_

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**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  
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 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 \_\_\_\_\_