TENNESSEE STATE UNIVERSITY BAND
STUDENT HEALTH FORM

Name _____ Social Security No. _____
Last First Middle

Date of Birth _____ Sex _____ Marital Status _____

Home Address _____
Street City State Zip Code

Parent or Guardian _____ Phone _____

1. Do you have hospitalization? _____ Company and policy number _____

   If you do not have insurance we strongly recommend that you obtain school insurance.
   Rate will be available during registration.

2. Have you ever had?

	Yes	No	Immunizations	Yes	No	Date
Measles	_____	_____	Tetanus	_____	_____	_____
Chicken Pox	_____	_____	Polio	_____	_____	_____
Whooping Cough	_____	_____	Measles	_____	_____	_____
Polio	_____	_____	Mumps	_____	_____	_____
Mumps	_____	_____	Whooping Cough	_____	_____	_____
Hepatitis	_____	_____	Diptheria	_____	_____	_____

3. Have you had surgery? _____ List surgery and date. _____

4. Have you been treated for any serious medical illness (hypertension, diabetes, asthma, epilepsy, sickle cell anemia)? _____ Give details. _____

5. Are you presently on any medication? _____ If so, list medication(s). _____

   _____

6. Do you have any allergies? _____

7. Have you ever been treated for any mental problems? _____

8. Is there a family history of a bleeding disorder, cancer, hypertension or diabetes? _____
   List and relationship. _____

If a student is under 18 years of age we need permission to treat the student or hospitalize for a serious illness at the discretion of a Student Health Physician.

Date _____ Signature of Applicant _____

Physician Signature _____ Parent of Guardian _____

Health examination form must be completed by a physician, nurse practitioner or a licensed physician's assistant.

Age _____ Height _____ Weight _____

1. Blood Pressure _____
2. Pulse Rate _____ Character _____

	Normal	Abnormal	Comments
3. Eyes	_____	_____	_____
4. Ears	_____	_____	_____
5. Nose and throat	_____	_____	_____
6. Sinuses	_____	_____	_____
7. Mouth and teeth	_____	_____	_____
8. Chest	_____	_____	_____
9. Heart	_____	_____	_____
10. Abdominal Viscera	_____	_____	_____
11. Endocrine Viscera	_____	_____	_____
12. Nervous system	_____	_____	_____
13. Lymphatic glands	_____	_____	_____
14. Orthopedic defects	_____	_____	_____

Have you previously tested positive for COVID-19? Yes_____ No_____ Date of positive test_____

If you have tested positive for COVID-19 have you since tested negative? Yes_____ No_____

Is there any condition that would prevent this student from participating in physical activities?

Yes_____ No_____ If yes please explain_____

_____

Physician Signature: _____

We recommend a tetanus booster if you have not had one in the last five years.

We recommend a tuberculin skin test if none has been done in the last 12 months.

***MUST BE SIGNED AND STAMPED BY PHYSICIAN OR HEALTH DEPARTMENT PROVIDING THE PHYSICAL EXAM.**