

**NOTRE DAME SEMINARY
GRADUATE SCHOOL OF THEOLOGY
MASTER OF DIVINITY PROGRAM**



CANDIDATE MEDICAL FORM

Candidate Medical Form

Notre Dame Seminary
Master of Divinity Program



The applicant must provide this information for admission to Notre Dame Seminary. Enrollment will be postponed until all necessary immunizations are brought up to date and this entire form is complete.

Date			
Name			
	<i>Last</i>	<i>First</i>	<i>Middle</i>
Permanent Address			
Date of Birth		Birthplace	
How long have you lived in the United States?			
Health Insurance Information	Company Name:		
	Policy Number:		
	Policy Holder Name:		
In case of emergency, whom should we notify?			
Name		Relationship	
Address			
City, State Zip			
Telephone			
FAMILY HISTORY			
Among your blood relatives is there any history or present illness of any of the following:			
	Yes	No	Relationship
CANCER			
HEART DISEASE			
HIGH BLOOD PRESSURE			
STROKE			
TUBERCULOSIS			
DIABETES			

	Yes	No	Relationship	
NERVOUS OR MENTAL DISEASE				
ASTHMA OR HAY FEVER				
CONVULSIONS				
Are your parents living?	Father		Mother	
Number of Brothers Living		Number of Sisters Living		
If deceased, give relationship and cause of death.				



Have you ever had or do you suspect that you may have (if yes, please explain):

Check Each Item	Yes	No	Explain
ANEMIA OR OTHER BLOOD DISEASE			
APPENDICITIS, ACUTE OR CHRONIC			
ARTHRITIS, SWOLLEN OR PAINFUL JOINTS			
ASTHMA, OR SHORTNESS OF BREATH			
BOILS			
BONE, JOINT, OR OTHER DEFORMITY			
CHRONIC OR FREQUENT COLDS			
CHRONIC COUGH			
CRAMPS IN LEGS			
DIABETES			
EAR, NOSE, OR THROAT TROUBLE, MASTOID, ETC.			
EATING DISORDER			
EPILEPSY OR CONVULSIVE DISORDER			
EYE PROBLEMS			
FOOT TROUBLE			
FREQUENT INDIGESTION			
FREQUENT OR PAINFUL URINATION			
GALL BLADDER TROUBLE OR GALL STONES			
HAY FEVER			
HEADACHES, FREQUENT OR SEVERE			
HEARING LOSS			
HEART DISEASE			
HERNIA OR RUPTURE			
HEPATITIS OR JAUNDICE			
HIGH OR LOW BLOOD PRESSURE			
LAMENESS			
LOSS OF ARM, LEG, FINGER, OR TOE			
LOSS OF MEMORY OR AMNESIA			
KIDNEY DISEASE, STONES, OR BLOOD IN URINE			

MALARIA			
MENINGITIS			
Check Each Item	Yes	No	Explain
MONONUCLEOSIS			
NERVOUS OR MENTAL DISEASE			
NEURITIS			
PAIN OR PRESSURE IN CHEST			
PAINFUL OR "TRICK" SHOULDER, ELBOW, KNEE			
PALPITATION OR POUNDING HEART			
PARALYSIS			
PNEUMONIA			
RHEUMATIC FEVER			
SCARLET FEVER			
SEVERE TOOTH OR GUM TROUBLE			
SINUS DISEASE			
STOMACH, LIVER OR INTESTINAL TROUBLE			
SOAKING SWEATS (NIGHT SWEATS)			
SKIN DISEASE OR RASHES			
THYROID TROUBLE			
TONSILLITIS			
TUBERCULOSIS			
TUMOR, GROWTH, CYST, CANCER			
VENEREAL DISEASE			
VERTIGO (DIZZINESS), FAINTING SPELLS			
LIST CHILDHOOD DISEASES	Yes	Date	No
CHICKEN POX			
DIPHThERIA			
RUBELLA (3-DAY OR GERMAN)			
RUBEOLA (MEASLES)			
MUMPS			
POLIO			
WHOOPING COUGH			
Have you ever:	Yes	No	
WORN A BRACE OR BACK SUPPORT			
HAD ALCOHOL OR DRUG ABUSE TREATMENT			
bled EXCESSIVELY AFTER SURGERY OR TOOTH EXTRACTION			
LIVED WITH ANYONE WHO HAD TUBERCULOSIS			
COUGHED UP BLOOD			
Do you smoke?	Yes	No	If yes, how much?
Do you drink alcoholic beverages?	Yes	No	If yes, how much?
Do you have an exercise program?	Yes	No	If yes, please explain.

Are you allergic to any drugs or medications? Explain in full.			
Do you require injections for allergies? Yes No How frequently?			
Are you currently taking any medications? Explain in full.			
Prescribing Doctor			
Do you have any special dietary needs? Explain:			
Question	Yes	No	If yes, please explain.
Have you ever been unable to take physical education or participate in sports because of your health?			
Have you been denied life insurance, rejected for military service, or refused employment because of your health?			
Have you consulted, been treated, or been counseled by a physician or clinic in the past five years?			
Have you ever had any serious illness, injury, or operation not listed above?			
Have you had a chest x-ray? If yes, give date and results.			
PHYSICAL EXAMINATION TO BE COMPLETED AND SIGNED BY PHYSICIAN			
I authorize the Rector of Notre Dame Seminary), the Admissions Committee, and the appropriate diocesan officials (bishop/director of vocations) access to my Medical Form, unless I revoke it in writing.			
<i>Student's Signature</i>		<i>Date</i>	
1. Age:	Height:	Weight:	
Build:	Slender	Medium	Heavy Obese
2. Blood Pressure:	S	D	Urinalysis: Albumin Sugar
Pulse			
3. Vision:	Right 20/	Right 20/	Glasses (Yes/No):
	Left 20/	Left 20/	Color Vision: Contact Lenses (Yes/No):

Check Each Item in Proper Column	Normal	Abnormal	Note: Give details of each abnormality.
HEAD, NECK, FACE, AND SCALP			
NOSE AND SINUSES			
MOUTH, TEETH, GINGIVA, AND THROAT			
Check Each Item in Proper Column	Normal	Abnormal	Note: Give details of each abnormality.
EARS – ACUITY, CANALS, DRUMS			
EYES – ACUITY, LIDS, PUPILS, MOTIONS			
LUNGS AND CHEST			
HEART			
VASCULAR SYSTEM (INCLUDE VARICOSITIES)			
ABDOMEN AND VISCERA (INCLUDE HERNIA)			
ANO-RECTAL AND PILONIDAL			
ENDOCRINE SYSTEM			
GENITO-URINARY SYSTEM			
UPPER EXTREMITIES			
LOWER EXTREMITIES (INCLUDE FEET)			
SPINE, OTHER MUSCULO-SKELETAL			
SKIN AND LYMPHATICS			
NEUROLOGICAL SYSTEM			
PSYCHIATRIC (PERSONALITY DEVIATION)			
OTHER:			
ANY SPECIAL TESTS USED FOR YOUR CLINICAL EVALUATION (BLOOD, EKG, ETC.)?			
Please attach to this completed form the results of the blood analysis INCLUDING the testing for HIV-antibody status.			
IMMUNIZATIONS			
Diphtheria Tetanus Pertussis	Tetanus-Diphtheria	Trivalent Oral Polio Vaccine	
Dose Month/Day/Year	Dose Month/Day/Year	Dose	Month/Day/Year
1st	1st	1st	
2nd	2nd	2nd	
3rd	3rd	3rd	
4th	Booster	4th	
5th	Booster		
Meningitis/Hepatitis B Disclosure (Louisiana Law demands disclosure of status of these immunizations for all resident students.)			
Meningococcal vaccine received: Yes _____ Date: _____ No: _____			
Hepatitis B vaccine received: Yes _____ Date: _____ No: _____			

Combined M/M/R (Measles/Mumps/Rubella) (Mo/Day/Yr):		
OR: Combined M/R (Measles/Rubella) (Mo/Day/Year):		
OR: Measles (Mo/Day/Year):	Mumps (Mo/Day/Year):	Rubella (Mo/Day/Year):
Tuberculosis Skin Test	Inactivated Polio Vaccine	
Dose Month/Day/Year	Dose Month/Day/Year	
Tuberculin Skin Test	1 st	
Tine	2 nd	
Mantoux	3 rd	
If skin test was POSITIVE, was a chest x-ray done? Yes No		
List any other immunizations:		
Indicate reason here if you have a medical condition that prevents vaccination of any of the above.		
Verify immunizations meet Louisiana requirements		
<input type="checkbox"/> Tetanus/Diphtheria (booster every 10 years)	<input type="checkbox"/> Polio (series of 3)	<input type="checkbox"/> MMR (2 injections after age of 12 months)
Every college student is required to enroll in the physical education program for two semesters. Check one below:		
<input type="checkbox"/> This student may participate in a program of physical education, which includes such sports as basketball, soccer, swimming, gymnastics, tennis, handball, bowling, and karate.		
<input type="checkbox"/> This student should be enrolled in a restricted program of physical education. I make this recommendation for this reason:		
<i>Physician's Name (Please Print)</i>		<i>Physician's Signature</i>
<i>Date</i>		
Phone Number		
Street Address		
City, State, Zip		