Notre Dame Seminary

Graduate School of Theology

Priestly Formation Program

Medical Form

Medical Form

Notre Dame Seminary
Priestly Formation 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 completed.

Name: ____
Last, First, Middle

Address: ____
Street address *City, State, Zip*

Date of Birth: __________________________________

Do you currently have health insurance? ☐ Yes ☐ No
If yes, please complete the following information:

Insurance Company Name: ____

Policy Number: ____________________________ **Group Number:** ___________________________

Policy Holder's Name: __________________________ **Relationship to you:** ____________________

In case of emergency, whom should we notify?

Name: _______________________________________ **Relationship:** __________________________

Address: ____
Street City, State Zip

Telephone: ____

When was your last physical examination? ____

Who is your physician? ____

Please indicate any physical challenges or limitations; serious illnesses or accidents and your age when it occurred:

____

____

____

Please indicate if you had any of the following:

Chicken Pox	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No
Diphtheria	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Rubella (3-day or German)	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Rubeola (Measles)	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Mumps	☐ Yes	☐ No	Irritable Bowel Syndrome	☐ Yes	☐ No
Polio	☐ Yes	☐ No	Crohn's Disease	☐ Yes	☐ No
Whooping Cough	☐ Yes	☐ No	Colitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Kidney Stones	☐ Yes	☐ No	Allergies	☐ Yes	☐ No

Additional Illnesses and/or surgeries to date:

____

____

PHYSICAL EXAMINATION TO BE COMPLETED AND SIGNED BY PHYSICIAN

INSTRUCTIONS: Please have your physician complete the following sections and sign the bottom of next page. You may attach a separate sheet to this packet listing your immunizations or a written dissent.

PHYSICAL EXAM

Check Each Item in Proper Column	Normal	Abnormal	Give details of each abnormality.
Head, neck, face, and scalp			
Nose and sinuses			
Mouth, teeth, gingiva, and throat			
Ears – acuity, canals, drums			
Eyes – acuity, lids, pupils, motions			
Lungs and chest			
Heart			
Vascular system (include varicosities)			
Abdomen and viscera (include hernia)			
Anal-rectal and pilonidal			
Endocrine system			
Male genitalia/urinary system			
Upper extremities			
Lower extremities (include feet)			
Spine, other muscular-skeletal			
Skin and lymphatics			
Neurological system			
Other:			

REQUIRED TESTING

Please attach to this completed form the results of the blood analysis INCLUDING Chromosome Analysis verifying biological maleness, HIV and drug testing.

IMMUNIZATIONS (complete and/or attach immunization record)

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: _______

Verify immunizations meet Louisiana requirements

- ☐ **Tetanus/Diphtheria or tDap (booster every 10 years)**
- ☐ **Polio (series of 3)**
- ☐ **MMR (2 injections after age of 12 months)**

Indicate reason if the seminarian has a medical condition that prevents vaccination of any of the above.

Every seminarian is required to maintain a program of physical fitness. *Please check one*

This seminarian _____ may or ______ may not participate in a program of physical fitness, which may include such sports as football, basketball, soccer, swimming, weight lifting, tennis, handball, bowling, and karate, or any other strenuous sport. If not, explain in full:

____

____

____

____

Physician's Signature *Date*

Physician's Name: ____________________________________

Phone Number: ______________________________________

Street Address: ______________________________________

City, State, Zip: ______________________________________