Candidate Medical Form

Priestly Formation Program
Pontifical College Josephinum

The student must provide this information for admission to the Pontifical College Josephinum. Enrollment will be postponed until all necessary immunizations are brought up to date and this entire form is complete.

☐ **College** ☐ **Pre-Theology** ☐ **Theology**

Date			
Name			
	Last	*First*	*Middle*
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 the Josephinum, the Student Health Center (nurse/physician), the Admissions Committee, and the appropriate diocesan officials (bishop/director of vocations) access to my Medical Form, unless I revoke it in writing.

Student's Signature	*Date*

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 HIVantibody status, and screening that verifies biological maleness. (PPF 6th Edition, pg 42, item 83)

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 (Ohio Law):

Combined M/M/R (Measles/Mumps/Rubella) (Mo/Day/Yr):

OR: Combined M/R (Measles/Rubella) (Mo/Day/Yr):

OR: Measles (Mo/Day/Yr): **Mumps** (Mo/Day/Yr): **Rubella** (Mo/Day/Yr):

Tuberculosis Skin Test		**Inactivated Polio Vaccine**	
Dose	**Month/Day/Year**	**Dose**	**Month/Day/Year**
Tuberculin Skin Test		1st	
Tine		2nd	
Mantoux		3rd	

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 Ohio requirements		
☐ **Tetanus/Diptheria (booster every 10 years)**	☐ **Polio (series of 3)**	☐ **MMR (2 injections after age of 12 months)**

Physician's Name (Please Print)	*Physician's Signature*	*Date*

Phone Number	
Street Address	
City, State, Zip	