SAN DIEGO MESA COLLEGE

International Student Program
Health Examination Report

7250 Mesa College Drive, San Diego, CA 92111-4998
Phone (619) 388-2717

Name: ______________________ ______________________ ______________ Date: ____________
(PLEASE PRINT) LAST FIRST MIDDLE

Country of Birth: __________________________ Country of Citizenship: ______________________________

A. ☐ COMPLETED BY STUDENT

Have you had or do you now have any of the following conditions? If yes, give approximate dates:

- ☐ AIDS/HIV (Human Immune Deficiency Virus)
- ☐ Allergy (severe)
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Blackouts
- ☐ Chicken Pox
- ☐ Depression
- ☐ Epilepsy Diabetes
- ☐ Epilepsy
- ☐ Heart Problem (restrictions)
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Intestinal Problems
- ☐ Kidney Disease
- ☐ Malaria
- ☐ Measles (Rebeola)
- ☐ Meningitis
- ☐ Migraine Headaches
- ☐ Mononucleosis
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Rubella (German Measles)
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Stomach Ulcer
- ☐ Other conditions (including but not limited to learning disabilities): ____________________ ____________________

☐ Any complications/restrictions due to the above conditions:

____

Do you have any conditions that would affect your ability to enroll in a full time course load of study?
Yes: ☐ No: ☐ If YES, please list names: ______________________________________

Give date and types of serious operation or injuries: ______________________________

Explain special health problems: ______________________________________

I understand that falsification or withholding information on the Health Examination report shall constitute grounds for denial of my application.

Applicant Signature: ______________________ Date: __________

B. ☐ MEDICAL CERTIFICATION: (COMPLETED BY MEDICAL PHYSICIAN)

Current immunization and tuberculosis clearance with dates specified must be completed and verified before acceptance to San Diego Mesa College.

1. Tetanus (must be within the past nine years). Date: ______________
2. Measles, Rubella (must be given after 1970 and after twelve months of age).
   Measles (Rubeola) Date:______________ Rubella Date:______________
3. Polio Date:______________ Diphtheria Date:______________
4. BCG inoculation Date:______________
   If no BCG, Tuberculosis clearance dated within the past three months of the physical exam:
   Mantoux skin test Date:______________ Result:______________________
   (If Mantoux test is positive, chest x-ray is required).
   Chest X-ray Date:______________ Result*:______________________
   *Attach copy of your chest x-ray report. Do not send the x-ray film.

Does student have any conditions which would prevent participation in physical education?
Yes* ☐ No ☐ *If YES, explain ______________________________

Does student have any conditions which would affect the student's ability to perform in an academic setting?
Yes* ☐ No ☐ *If YES, explain ______________________________

Special Health Problems: ______________________________________
____

I have examined ______________________ and I find him/her in good health and able to attend college.
STUDENT NAME

Signature of Physician: ______________________ Date: ______________

Name of Physician: ______________________________________
PLEASE PRINT

Address ______________________________________

Email:______________________________________

Phone Number: ______________ Physician Stamp or Business Card