

# PHYSICAL EXAMINATION

## Relative to Application for Admission to God's Bible School and College

Name (First, Middle, Last): \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_ Vision: Without Glasses \_\_\_\_\_ With Glasses \_\_\_\_\_

Check the proper column for each item	Normal	Abnormal	Details of Abnormalities
1. Mouth/Teeth			
2. Throat/Tonsils			
3. Nose/Sinuses			
4. Hearing			
5. Lungs/Chest			
6. Heart (estimate cardiac function)			
7. Abdomen			
8. Endocrine System			
9. Genito-Urinary System			
10. Skin			
11. Neurological System			

Explain all "yes" answers. If additional space is needed, please use reverse side.

- |  |  |
|--|--|
| 1. Is there a present illness?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Is there a history of any serious illnesses?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Is the individual allergic to any drug?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Does the individual have any allergies?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Does the individual show signs of emotional instability?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Is the individual presently on any drugs?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Is there any reason why the individual should not take physical education classes?              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Does this person or his/her family have any history of epilepsy, mental illness or nervousness? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Required for Admission: (Must give month/day/year for each)**

PPD:  Negative  Positive Date: \_\_\_\_\_  
*(Required for foreign students only or those returning from an overseas mission. If positive, must have chest x-ray.)*

Date of last tetanus: \_\_\_\_\_

MMR (Measles, Mumps, Rubella) 2 Vaccines: Date \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date of Exam \_\_\_\_\_

Doctor's Business Address \_\_\_\_\_

Doctor's Business Phone Number \_\_\_\_\_

To be completed and mailed by the examining physician.

Office of Admissions  
 God's Bible School and College  
 1810 Young Street  
 Cincinnati, OH 45210