HEALTH INFORMATION FORM
(Return to Admission Office)

P.O. BOX 130 South Canaan, PA 18459-0130

FORM C

Name of Applicant: _____ Social Security Number _____

Current Address: _____

_____ Telephone: _____

In case of emergency, please notify: _____ Relationship: _____

Address: _____

_____ Telephone: _____

Have you been treated for, have you ever had, or do you now have, any of the following? For each 'Yes' checked, describe or explain below or on a separate sheet:

1. Frequent or severe headaches	YES ☐	NO ☐	13. Kidney stones	YES ☐	NO ☐	26. Venereal disease	YES ☐	NO ☐
2. Dizziness or fainting spells	YES ☐	NO ☐	14. Blood in urine	YES ☐	NO ☐	27. Immunizations	YES ☐	NO ☐
3. Unconsciousness for any reason	YES ☐	NO ☐	15. Sugar or albumin in urine	YES ☐	NO ☐	Hepatitis B	YES ☐	NO ☐
4. Eye trouble (except glasses)	YES ☐	NO ☐	17. Epilepsy or seizures	YES ☐	NO ☐	Rubella	YES ☐	NO ☐
5. Hay fever	YES ☐	NO ☐	18. Nervous trouble of any sort	YES ☐	NO ☐	Influenza	YES ☐	NO ☐
6. Asthma	YES ☐	NO ☐	19. Mental trouble	YES ☐	NO ☐	Tetanus	YES ☐	NO ☐
7. Allergies to medications or other drugs	YES ☐	NO ☐	20. Attempted suicide	YES ☐	NO ☐	Mumps	YES ☐	NO ☐
8. Diabetes (insulin)	YES ☐	NO ☐	21. Motion sickness requiring medication	YES ☐	NO ☐	Other	YES ☐	NO ☐
9. Heart trouble	YES ☐	NO ☐	22. Hospital admissions	YES ☐	NO ☐	28. Blood serology	YES ☐	NO ☐
10. High/low blood pressure	YES ☐	NO ☐	23. Operations involving eyes, brain, heart, nerves or blood vessels.	YES ☐	NO ☐	29 Other illnesses	YES ☐	NO ☐
11. Anemia or other blood disorders, including abnormal bleeding	YES ☐	NO ☐	24. Amputations or physical disabilities	YES ☐	NO ☐	30. Chest x-ray or blood test for TB	YES ☐	NO ☐
12. Stomach trouble	YES ☐	NO ☐	25. Hepatitis	YES ☐	NO ☐	31. Other	YES ☐	NO ☐

Explain (indicate item number):

Blood Type _____ Previous Transfusion Reaction? _____ If yes, what reaction: _____

Contact Lenses? Dentures? Other:

Do you have Medical Insurance? YES ☐ NO ☐ If yes, specify Carrier and Policy Number: _____

Will insurance continue during your studies at St. Tikhon's Seminary? _____

If either of your parents or any siblings are deceased, please indicate cause and age of death:

Have you ever discontinued study or work because of physical, mental or emotional illness? If so, give dates and circumstances:

Are you at present under regular medical and/or psychological care of someone other than the examining physician below? If so, please ask that physician, counselor or therapist to submit a statement describing your capacity to successfully pursue and complete a program of study in theology.

Are you at the present time regularly taking either prescription or over-the-counter medication? Please list and explain:

Please indicate any exceptional medical conditions and/or circumstances that you feel need to be taken into account by the Admissions Committee:

I hereby certify that to the best of my knowledge, the information given above is true and accurate.

Applicant's signature *Date*

Examining Physician's Statement:

General health of the applicant: ☐ Excellent ☐ Good ☐ Fair

Is the applicant a carrier of any communicable disease or HIV?

Any special limitations or restrictions on physical activity?

Examining Physician (Signature) Date

Physician's Name (Type or Print)

Address City, State, Zip

8/05