

RC Program Student Medical Exam Form

Return by designated deadline: Southwestern Illinois College – RC Program • 2500 Carlyle Ave • Belleville, IL 62221 • Fax: (618) 235-2052

Section 1 – Personal Information

Student completes this section.

Student Name (last, first, middle): _____

Street Address: _____ Phone Number: _____

City, State, Zip: _____ Date of Birth: _____

SWIC Student Email Address: _____ @swic.edu

Emergency Contact:

Name: _____ Relationship: Spouse Parent Other: _____

Phone: _____

Section 2 – Medical History

Student completes this section. Medical examiner is encouraged to discuss with student.

Check all that apply – use the space below to provide details:

- | | |
|--|---|
| <input type="checkbox"/> Heart disease or heart attack | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Heart murmur or Arrhythmia | <input type="checkbox"/> Stroke or paralysis |
| <input type="checkbox"/> Fainting/dizziness | <input type="checkbox"/> Headaches/migraines |
| <input type="checkbox"/> Diabetes (specify control method) | <input type="checkbox"/> Neurological disorder |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Seizure disorder/Epilepsy |
| <input type="checkbox"/> Eye disorder/vision loss | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Ear disorder/hearing loss | <input type="checkbox"/> Shortness of breath, asthma, cough or hoarseness |
| <input type="checkbox"/> GERD, Chron's disease, IBS, etc | <input type="checkbox"/> Pulmonary disease |
| <input type="checkbox"/> Any allergic reaction (drug, food, product, latex, etc) | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Skin disease | <input type="checkbox"/> Cancer (specify type) |
| <input type="checkbox"/> Back injury, scoliosis or chronic lower back pain | <input type="checkbox"/> Abnormal bleeding |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Major Surgery |
| <input type="checkbox"/> Orthopedic disorder | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Mental disorder/emotional instability | <input type="checkbox"/> Other _____ |

Provide details from all boxes checked above (attach additional sheets if more room is needed):

List any current medications or treatments (attach additional sheets if more room is needed):

Student: Read, Sign and Date

The information I have provided is complete and accurate to the best of my knowledge and I have attached all laboratory results. I understand that failure to complete this form correctly may jeopardize my participation in the clinical portion of this program.

Signature: _____ Printed Name: _____ Date: _____

