



College of the Marshall Islands

Accredited by the Western Association of Schools and Colleges

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Office of Admissions & Records

HEALTH EXAMINATION FORM

Instructions: This health form requires the applicant to have a complete physical examination by a certified physician at your local hospital in order to fulfill this health form requirement.

Name: _____
(Last Name) (First Name) (Middle Initial)

(Date of Birth) (Sex) (Home State)
Blood Pressure _____/_____ Pulse _____ Height _____ Inches
Vision R20/____ L20/____ Corrected: Y N Weight _____ Pounds
Pupils- Equal ____ Unequal ____
Allergies: _____
Medical Problem: _____

Medical	Normal	Abnormal Findings
Appearance		
EENT		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitourinary		
Skin		
Neck		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arms		
Elbows/Forearms		
Wrists/Hands/Fingers		
Knees		
Legs/Ankles		
Foot/Toes		

Required Immunizations

Measles/Mumps/Rubella Dates
(2 MMRs required)
Dose #1 (Month/Day/year) _____
Dose #2 (Month/Day/Year) _____
Chicken Pox/Varicella _____
Did student have disease? YES NO
Date of Disease _____
Tetanus/Diphtheria _____
(Td or Tdap)
Polio (series, completed) _____

REQUIRED SCREENING **Tuberculin Skin Test- (PPD)**

Given within the last year, one year prior
to beginning of first term at CMI

Date/Time Given _____
Date/Time Read _____
Result: Negative Positive
Induration: _____ mm
If positive, any treatment given Y N

RECOMMENDED IMMUNIZATIONS

Meningococcal _____
Hepatitis A Dose #1 _____
Dose #2 _____
Hepatitis B Dose #1 _____
Dose #2 _____
Dose #3 _____

Clearance for Athletic Participation at CMI

____ Cleared for participation in _____
List Sports
____ Cleared after completing evaluation/rehabilitation for: _____
____ Not Cleared for: _____ Reason: _____

Health Care Provider (Signature Required)

Signature: _____ Name (Print) _____ Date _____
Clinic Name: _____ Phone () _____ Fax () _____
Address _____
Street City State Zip Code