MORRIS COLLEGE
1908 Our second century 2008

100 West College Street ♦ Sumter, South Carolina 29150-3599
(803) 934-3200 ♦ Fax (803) 773-8241 ♦ Toll-free (866) 853-1345
www.morris.edu

Note: This form is available for download on the Morris College website.

MEDICAL EXAMINATION FORM

Must be completed by a physician.

I. PERSONAL DATA

Applicant's Name: _____ _____ _____
Last First Middle

Home Mailing Address: _____
Number and Street or RFD

_____ _____ _____ _____
City State Zip Code Phone No.

Name, address, and phone number of another person to notify in case of an emergency: _____

_____

Gender: ☐ Male ☐ Female Date of Birth: _____

Height: _____ Weight: _____ BP _____ HGB _____ UA _____ PPD _____

Eyes: _____ (L) _____ (R) _____ Nose _____

Ears: _____ (L) _____ (R) _____ Throat/Gums/Teeth _____

Neck: _____

Chest: _____

Abdomen: _____

Extremities: _____

Neurological: _____

Skin: _____

Psychological: _____

Previous illness / injuries / hospitalizations: _____

_____

Currently Prescribed Medicines: _____

Allergies: _____

Any additional history?

Examined by: _____

Date _____ Address _____

_____

OVER

Must be completed by a physician.

IMPORTANT • IMMUNIZATION REQUIREMENT • IMPORTANT

In keeping with state and national health issues, Morris College requires all students born after December 31, 1956 to furnish proof of receiving measles (rubeola) and German measles (rubella) vaccine prior to registration.

Proof of immunity requires documentation of the following:
Receiving measles and German measles (MR and MMR) vaccine shot.

Please complete the following form and return it to the Office of Admissions and Records, Morris College, 100 West College Street, Sumter, South Carolina 29150. If you have questions, call the Office of Admissions and Records at 803-934-3225 or Health Services Center at 803-934-3256, or Fax to 803-773-3687.

REQUIRED IMMUNIZATION INFORMATION

Applicant for: ☐ Fall ☐ Spring ☐ Summer I ☐ Summer II Year_____

Name: _____ _____ _____
Last First Middle

Home Mailing Address: _____
Number and Street or RFD

_____ _____ _____
City State Zip Code

_____ _____ Gender: ☐ Male ☐ Female

Allergies:_____

_____ Photocopy of immunization enclosed.

_____ My immunization information, certified by a licensed health professional, is listed below.

CERTIFICATION

(MMR includes Measles, Mumps, and Rubella)

Date of Immunization: _____

I certify the above information is correct:

Licensed Health Professional _____
Signature