



Office of Admissions
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Applicant's Physical Examination Form

To be completed by a physician.

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Applicant's Name:

Do you consider the applicant's health adequate for intensive schoolwork?

Are there any physical deformities?

Does the applicant suffer from any form of nervous or mental disturbance?

Does the applicant require a special diet?

Does the applicant require special or regular medication?

Is the applicant free of all infectious and contagious diseases?

Are there any indications that the applicant has been engaged in the illicit use of drugs or addicted to narcotics or alcohol?

Is hearing normal?

Is speech normal?

Are eyes normal?

Does applicant need corrective lenses?

CHALLENGING LEADERS TO CHANGE THE WORLD



Applicant's Physical Examination Form

To be completed by a physician.

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Applicant's Name:

Does the applicant have a history of any of the following?

- | | | | |
|--------------------------------------|-------------------------------------|---|---|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Severe Headaches |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Stomach Trouble |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Brain Tumor | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Menstrual Disorder | <input type="checkbox"/> Venereal Disease |

Are there any special weaknesses or conditions to be considered?

<i>Immunizations</i>	<i>Dates Received</i>			Comments
	(MM/DD/YY)	(MM/DD/YY)	(MM/DD/YY)	
Hepatitis B (3 doses required)				
MMR (2 doses required)				Waived if born in USA before 1957
Varicella (2 doses required)				Waived if born in USA before 1980
Tdap (1 dose required)				
Meningococcal conjugate (1 dose required)				Required of residential students only
Results of Mantoux or Tine test (recommended):				

Remarks:

Physician's Signature:

Date:

Print Name:

Address:

Telephone:

City:

State:

Zip Code: