TENNESSEE COLLEGE OF APPLIED TECHNOLOGY
JACKSON

MEDICAL RECORD

STUDENTS NAME: _____

PROGRAM AREA: _____

DATE OF LAST PHYSICAL EXAMINATION: _____

STATE PHYSICAL HANDICAPS, CHRONIC ILLNESS, MENTAL OR NERVOUS DISORDERS WHICH MAY BE OR BECOME A LIMITATION FACTOR FOR ANY POSITION IN THE FIELD OF EMPLOYMENT, ENROLLED IN FOR TRAINING:

_____

_____

_____

STATE ANY CONDITIONS THAT THE INSTRUCTOR WOULD NEED TO KNOW TO INSURE A MORE EFFECTIVE TRAINING PROGRAM: (FEET AND ARCHES, EYES, EARS, ALLERGIC REACTIONS, HEART, THROAT, ARTHRITIS, ETC.)

_____

_____

_____

IN CASE OF ACCIDENT OR EMERGENCY, PLEASE CONTACT:

NAME	RELATIONSHIP	ADDRESS	PHONE NUMBER

PHYSICIAN'S NAME: _____ **PHONE NUMBER:** _____

ARE YOU ALLERGIC TO ANY DRUGS OR TREATMENTS? IF SO SPECIFY.

_____

_____

In case of accident or serious illness if the school is unable to contact the person(s) listed above, I hereby authorize the school to take me to the physician indicated. If it is impossible to contact this physician, the school may take me to another physician or to a hospital authorized by the board of health.

Completing this form is not a request for accommodations due to a disability.

_____ _____

Signature of Student **Date**