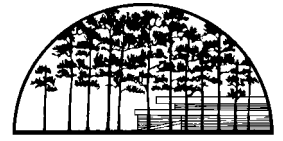


Physical Examination Waiver

I hereby request waiver of a physical examination and release RCC of liabilities that may thus develop due to the lack of a physical examination. I also accept the responsibility for my physical well being at RCC. I understand that RCC reserves the right to request a physical examination.



**Rockingham
Community College**

P.O. Box 38
Wentworth, NC 27375-0038
(336) 342-4261
TTY: (336) 634-0132

Applicant's Signature

Month / Day / Year

Self-Reported Medical History

(This portion of the form is recommended, but optional.)

The information you provide on this form will be used to help and protect you while enrolled as a student at RCC rather than to prevent your being enrolled. It is important that you answer all questions accurately and completely. This information is to be used for the planning of facilities and in no way affects your admission. Rockingham Community College complies fully with Section No. 504 of the Rehabilitation Act of 1973 and Americans with Disabilities Act (ADA) of 1990.

Social Security Number: _____ Birthdate: _____

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

Address: _____ Telephone: _____

In case of an emergency, who should be notified?

Name: _____ Relation: _____

Address: _____
Street City State Zip

Emergency Telephone (day): _____ (night) _____

1. Have you had any of the following? If so, please check the space in front.

<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Allergies	<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Other Blood Disease
<input type="checkbox"/> Chronic Sinus Trouble	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Heart Trouble
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Trouble
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Malaria	<input type="checkbox"/> Hernia
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> High or Low Blood Pressure	<input type="checkbox"/> Mononucleosis

If so, please explain: _____

2. Please list any additional illnesses or operations and give dates: _____

3. At present, are you taking any prescribed drugs or are you under medical treatment? No _____ Yes _____ If so, what?

4. Family physician: _____
Name Address Phone

5. Hospitalization Insurance: _____
Name of Company Policy Number if known

6. In case of emergency, I am willing to be taken by ambulance to the nearest hospital. No _____ Yes _____