

# Student Health Form - PAGE 1

(Front to be completed by student; back by physician)

*The information on this form is confidential and will not be released to anyone without your knowledge and consent.*

Approved	_____	_____	_____
	Date		NP
Not Approved	_____	_____	_____
	Date		NP

## I. General Information *(please print)*

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_ Sex  Male  Female

Address \_\_\_\_\_  
Street City State Zip

Parent/Guardian \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

## II. Health History – Family

*Has anyone in the family ever had any of the following:*

	Age	State of Health	Age at Death	Cause of Death <i>(if deceased)</i>	Yes	No	Relationship
Father:							
Mother:							
Brother(s):							
Sister(s):							

## III. Health History – Personal

*Have you ever had or do you now have (check yes or no):*

	Yes	No		Yes	No
Chicken Pox			Psychiatric Disorders		
Hepatitis			Anxiety Reactions		
Infectious Mononucleosis			Chronic Skin Problems		
Tuberculosis or contact with Tuberculosis			Neurological Disorders		
Rheumatic Fever			Epilepsy		
Eye, Ear, Nose problem or injuries			Fainting Spells		
Heart Problem(s)			Head injury with unconsciousness		
Heart Murmur			Endocrine Disorder(s)		
High Blood Pressure			Diabetes Mellitus		
Irregular or Rapid Heart Beat			Anemia		
Pain or Pressure in the Chest			Allergies to Medications and/or Food		
Asthma			Physical Handicap(s)		
Significant Allergic Reaction(s)			Serious Accident(s)		
Chronic or Recurrent Gastrointestinal Problems			Operation(s)		
Kidney Problems			Have you been hospitalized?		
Hernia			Are you taking medication currently? (list)		
Eating Disorder			Other medical problems (please list)		
Mental Illness					

*Please elaborate on any "Yes" answers on additional sheet(s) as necessary. Indicate diagnosis, treatment, if the condition is still present, or if you have recovered. Record any significant medical problems not covered in the above list.*

**Current Medication(s) and Dose(s)** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### IV. Clinical Evaluation

Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_ Vision *Uncorrected* *Corrected*  
 Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ Pulse \_\_\_\_\_ *Reg. / Irreg.* *Right* 20/ \_\_\_\_\_ 20/ \_\_\_\_\_  
 Urinalysis: Alb. \_\_\_\_\_ Sugar \_\_\_\_\_ Micro \_\_\_\_\_ (optional) *Left* 20/ \_\_\_\_\_ 20/ \_\_\_\_\_

Normal	Abnormal	Check each item in proper column (N.E. if not evaluated)	Give details of each abnormality.
		1. Head, Neck, Face, and Scalp	
		2. Nose and Sinuses	
		3. Mouth and Throat	
		4. Teeth and Gingiva	
		5. Ears (Perf. of drum, etc.), Hearing	
		6. Eyes (lids, conjunctiva, etc.)	
		7. Pupils and Ocular Motion	
		8. Lungs, Chest and Breasts	
		9. Heart (Note any restriction of activity)	
		10. Vascular System (Varicosities, etc.)	
		11. Abdomen and Viscera (include hernia)	
		12. Ano-rectal (pilonidal)	
		13. Endocrine System	
		14. G-U System	
		15. Upper Ex. (strength, range of motion)	
		16. Feet	
		17. Lower Ex. (as for upper)	
		18. Spine, other Musculo-skeletal	
		19. Skin and Lymphatics	
		20. Neurologic	
		21. Psychiatric (including personality deviations)	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	22. Is this student physically able to participate in intercollegiate athletics? <i>If not please elaborate on any contraindications or any medical or orthopedic conditions requiring further treatment:</i>	

### V. Required Information

**Within the past 6 months:**

PPD: Date \_\_\_\_\_ Results \_\_\_\_\_ OR Chest x-ray: Date \_\_\_\_\_ (attach report)

**Immunizations**

	Dates (mo,day,yr)	Dates (mo,day,yr)
Measles – Two immunizations, serology or physician-documented illness	____/____/____	Diphtheria/Pertussis/Tetanus (DPT)
Mumps – Immunization or physician-documented illness	____/____/____	Series Completed
Rubella – Immunization or Rubella Titer	____/____/____	Tetanus/Diphtheria (TD)
OR		Booster within last 10 years
MMR (Measles/Mumps/Rubella) (two immunizations)	____/____/____	Polio – Series Completed
		Booster

**Recommended**

- Hepatitis A vaccine (two shots) (indicate mo,day,yr) 1. \_\_\_\_/\_\_\_\_/\_\_\_\_ 2. \_\_\_\_/\_\_\_\_/\_\_\_\_
- Hepatitis B vaccine (three shots) (indicate mo,day,yr) 1. \_\_\_\_/\_\_\_\_/\_\_\_\_ 2. \_\_\_\_/\_\_\_\_/\_\_\_\_ 3. \_\_\_\_/\_\_\_\_/\_\_\_\_
- Meningococcal meningitis vaccine - Check type:  Menomune  Menactra (indicate mo,day,yr) \_\_\_\_/\_\_\_\_/\_\_\_\_
- Quadrivalent HPV vaccine (indicate mo,day,yr) 1. \_\_\_\_/\_\_\_\_/\_\_\_\_ 2. \_\_\_\_/\_\_\_\_/\_\_\_\_ 3. \_\_\_\_/\_\_\_\_/\_\_\_\_

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Printed Name of Examining Physician \_\_\_\_\_ Phone / fax \_\_\_\_\_ Date \_\_\_\_\_

Printed Address of Examining Physician \_\_\_\_\_ Signature of Examining Physician \_\_\_\_\_