

Student Health Form - PAGE 1

(Front to be completed by student; back by health care provider)

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 <i>Uncorrected</i> <i>Corrected</i>
Blood Pressure _____ / _____	Pulse _____	Reg. / Irreg.	<i>Right</i> 20/ _____ 20/ _____
Urinalysis: Alb. _____	Sugar _____	Micro _____ (optional)	<i>Left</i> 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	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	21. Psychiatric (including personality deviations)	
		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) Series Completed
Mumps – Immunization or physician-documented illness	____/____/____	Tetanus/Diphtheria (TD) Booster within last 10 years
Rubella – Immunization or Rubella Titer	____/____/____	Polio – Series Completed
OR		Booster
MMR (Measles/Mumps/Rubella) (two immunizations)	____/____/____	____/____/____

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. ____/____/____

Printed Name of Examining Health Care Provider _____ Phone / fax _____ Date _____

Printed Address of Examining Health Care Provider _____ Signature of Examining Physician _____

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