# STUDENT HEALTH HISTORY FORM (5f)

☒ Downloadable ☒ Trackable

For details about this form or any others, use the Gustavus Enrollment Checklist 2010 at gustavus.edu/go/myd.

*Please complete all pages and return directly to Student Health Service in the envelope provided one month prior to the start of the semester.*

**Return to: Gustavus Adolphus College | Student Health Service | 800 West College Avenue | St. Peter, MN 56082**
**Phone: 507-933-7630 | FAX: 507-933-6074 | health-service@gustavus.edu**

## CONFIDENTIAL (To be completed by student)

Name: _____ Birth date: ____ / ____ / ____
*Last First Middle* *Month Day Year*

First name preference: _____ ☐ Male ☐ Female

Permanent address: _____ City: _____

State: _____ Country: _____ ZIP: _____ Phone: (____) _____

Cell phone: (____) _____

Father's name: _____ Home phone: (____) _____

Cell phone: (____) _____ Work phone: (____) _____

Mother's name: _____ Home phone: (____) _____

Cell phone: (____) _____ Work phone: (____) _____

Date entering Gustavus: ____ / ____ / ____ Admission status: Class of 20___ ___ ☐ New Student ☐ Returning ☐ Transfer
*Month Day Year*

**Emergency contact information if different than above:**

Name: _____ Relationship: _____

Work phone: (____) _____ Home phone: (____) _____ Cell phone: (____) _____

## HEALTH INSURANCE

*All students are enrolled in the supplemental insurance plan – information will be mailed in late July. If your family policy coverage is adequate, you may waive the premium by completing the online waiver by August 31st. Completing the following information does not waive you from that policy. We also suggest that students carry a current insurance card with them.*

**Policy Holder** Name: _____ **Policy Holder** Birthdate: _____

**Policy Holder** Address: _____
*City State ZIP*

**Policy Holder** Employer: _____ **Policy Holder** is my: Mother Father Self Other _____
*Circle One*

**ATTACH a copy of the front and back of your insurance card OR complete the following:**

Insurance Company Name: _____

ADDRESS: _____
*City State ZIP*

ID/Policy Number: _____ Group Number: _____

***Do you have secondary Insurance Coverage? ☐ No ☐ Yes — Attach a copy of secondary insurance card and policy holder information

## NCAA SPORTS PARTICIPATION / RELEASE OF INFORMATION

**For students planning to participate in an NCAA sport:** *I do not know of any existing or additional health reason that would preclude participation in sports. I certify that the answers on this health form are true and accurate. I am planning to participate in athletic activities. I hereby authorize release to Gustavus Adolphus College athletic trainers and medical providers the information contained in this entire document.* ***Please note that NCAA participants are required to have a physical within six months of the first day of practice.***

_____ _____
*Student Signature (or parent or legal guardian if under 18 years of age)* *Date*

## TO BE COMPLETED BY THE STUDENT BEFORE PHYSICAL EXAMINATION

Name: _____ Birth date: _____ / _____ / _____
*Last* *First* *Middle* *Month* *Day* *Year*

## FAMILY HISTORY

**HAVE ANY OF YOUR RELATIVES EVER HAD ANY OF THE FOLLOWING?**

1) Epilepsy
2) Headaches
3) Mental Illness (depression/anxiety/ other)
4) Kidney Disease
5) Diabetes
6) Thyroid Disease
7) Hayfever
8) Asthma
9) Anemia
10) Bleeds Easily
11) Osteoporosis
12) Arthritis
13) Heart Disease
14) Stroke
15) High Blood Pressure
16) High Cholesterol
17) Alcohol/Drug Addiction
18) Hepatitis
19) Cancer
20) Tuberculosis
21) HIV

Mother: _____
Father: _____
Brother: _____
Sister: _____

Father's occupation: _____ Mother's occupation: _____

Please list number of brothers and sisters with their ages: _____

Are you adopted: ☐ Yes ☐ No If your parents are divorced, how old were you at the time of the divorce? _____

With whom do you live? ☐ Parents ☐ Mother ☐ Father ☐ Spouse ☐ Self ☐ Other _____

## MEDICAL HISTORY

**ALLERGIES: Do you have any allergies to:**

Medications (please list) _____

Food _____

Environmental _____

Latex _____

**MEDICATIONS TAKEN REGULARLY:** (include allergy shots, birth control, pain control, laxatives, vitamins, diet pills, antidepressants, inhalers, etc.)

Name of Provider prescribing medication: _____ Phone: _____

Medication/Dosage: _____

Medication/Dosage: _____

**SURGERIES/ACCIDENTS/HOSPITALIZATIONS:** _____

**CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.**

☐ Decreased hearing
☐ Ringing in ear ☐ Ear infections
☐ Dizzy spells ☐ Fainting spells
☐ Vision problems
☐ Severe head injury / concussion
☐ Nose bleeds - *recurrent*
☐ Sinus trouble
☐ Sore throats - *frequent*
☐ Hoarseness - *prolonged*
☐ Hayfever / Allergies
☐ Pneumonia / Pleurisy
☐ Bronchitis / Chronic cough
☐ Asthma / Wheezing
☐ Shortness of breath:
☐ on exertion ☐ lying flat
☐ Chest pain
☐ High blood pressure
☐ Heart murmur ☐ Swollen ankles
☐ Irregular pulse ☐ Palpitations
☐ Leg pain - *when walking*
☐ High cholesterol
☐ Cold, numb feet or hands
☐ Hair loss
☐ Loss of appetite - *recent*
☐ Difficulty swallowing
☐ Heartburn ☐ Peptic ulcer

☐ *Persistent* nausea / Vomiting
☐ Abdominal pain - *chronic*
☐ Gall bladder trouble
☐ Jaundice / Hepatitis
☐ Diarrhea ☐ Constipation
☐ Diverticulosis ☐ Crohn's /Colitis
☐ Bloody or tarry stools
☐ Hemorrhoids ☐ Hernia
☐ Urinating frequently
☐ with leakage ☐ with pain
☐ Blood in urine ☐ Kidney stones
☐ Urine infections - *frequent*
☐ Sexually transmitted diseases
Type: _____
☐ Weight-loss ☐ Gain - *recent*
☐ Anemia ☐ Bruise easily
☐ Blood transfusions
☐ Mononucleosis
☐ Cancer ☐ Chronic fatigue
☐ Diabetes ☐ Thyroid disease
☐ Seizures ☐ Stroke
☐ Tremor / hands shaking
☐ Numbness / tingling sensations
☐ Headaches - *frequent*
☐ Arthritis / Rheumatism
☐ Back pain - *recurrent*

☐ Bone fracture / joint injury
☐ Foot pain ☐ Tattoos
☐ Rashes ☐ Hives
☐ Psoriasis ☐ Eczema
☐ Rheumatic fever ☐ Scarlet fever
☐ Polio ☐ Mumps
☐ Measles ☐ German measles
☐ Tuberculosis ☐ Herpes
☐ Aids / HIV ☐ Malaria / tropical diseases
☐ Sleeping or concentration difficulty
☐ Depression ☐ Anxiety
☐ Agitation ☐ Suicidal thoughts
☐ Self injury/cutting ☐ Suicidal attempts
☐ Phobias ☐ Mental illness
☐ Feelings of worthlessness
☐ History of alcohol / drug addiction
☐ Anorexia ☐ Eating disorder
☐ Bulimia
☐ Emotional / physical / sexual abuse

**SOCIAL HISTORY:**

Do you now or have you ever consumed:
Cigarettes ☐ Y ☐ N Pk./day ___
Alcohol ☐ Y ☐ N Drinks/wk. ___
Caffeine ☐ Y ☐ N Cups/day ___
Street Drugs ☐ Y ☐ N

**SPORTS HISTORY:** Have you ever…
☐ been restricted from sports or physical exercise?
☐ fainted during exercise?
☐ had chest pain or a racing heart during exercise?
☐ wheezed or coughed during exercise?
☐ had a family member die of sudden death before age 50?
☐ had signs or symptoms of marfans?

**MALES:** - *Please complete*
☐ Undescended testicle, testicular mass, lump

**FEMALES:** - *Please complete*

**Menstrual flow:**
☐ Reg. ☐ Irreg. ☐ Pain / cramps
Days of flow ___ Length of cycle ___
Date - 1st day of last period
_____
☐ Pain / bleeding during or after sex
Number of:
Pregnancies ___ Abortions ___
Miscarriages ___ Live births ___
Birth control method _____
B.C. pill (name) _____
Date of last PAP test _____

Other: _____

# IMMUNIZATION RECORD

**Required to be completed and returned to Health Service before the first day of class.**

Name: _____ Birth date: _____ / _____ / _____
*Last* *First* *Middle* *Month* *Day* *Year*

## REQUIRED IMMUNIZATIONS

**Minnesota law requires proof of immunization against Measles, Mumps, Rubella, Tetanus and Diphtheria.** You are age exempt for these vaccines if you were born before January 1, 1957. Age exempt? ☐ Yes ☐ No
You may also attach a copy of your high school immunization records which shows the following immunizations.

**MMR** (Measles, Mumps, Rubella) One dose required after 12 months of age. 1. _____ / _____ / _____ 2. _____ / _____ / _____
*Month Day Year* *Month Day Year*

**TD** (Tetanus-Diphtheria booster) One dose required within the **last 10 years**. 1. _____ / _____ / _____ ☐ Td, or ☐ Tdap?
*Month Day Year*

## RECOMMENDED IMMUNIZATIONS

Meningitis 1. _____ / _____ / _____ ☐ Menomune, or ☐ Menactra?
*Month Day Year*

Hepatitis A 1. _____ / _____ / _____ 2. _____ / _____ / _____
*Month Day Year* *Month Day Year*

Hepatitis B 1. _____ / _____ / _____ 2. _____ / _____ / _____ 3. _____ / _____ / _____
*Month Day Year* *Month Day Year* *Month Day Year*

(HPV) Gardasil 1. _____ / _____ / _____ 2. _____ / _____ / _____ 3. _____ / _____ / _____
*Month Day Year* *Month Day Year* *Month Day Year*

Varicella–Either a history of chicken pox, two doses of the vaccine given at least one month apart if immunized after age 13, or attach copy of positive varicella antibody. History of illness? ☐ Yes ☐ No

Dates of vaccinations: 1. _____ / _____ / _____ 2. _____ / _____ / _____
*Month Day Year* *Month Day Year*

History of reaction to immunization? ☐ Yes ☐ No Which immunization? _____

## CONSCIENTIOUS / RELIGIOUS EXEMPTION

**MUST BE NOTARIZED** **MUST FILL OUT IF UNABLE TO MEET REQUIRED IMMUNIZATIONS DUE TO CONSCIENTIOUS OR RELIGIOUS BELIEF.**

*I hereby certify by notarization that my conscientious or religious belief is opposed to immunizations.*

_____ _____
*Student Signature (or parent or legal guardian if under 18 years of age)* *Date*

Subscribed and sworn to me on the _____ day of _____ , 20___ ___.

_____
*Signature of Notary*

## MEDICAL EXEMPTION

**MUST BE COMPLETED IF UNABLE TO MEET REQUIRED IMMUNIZATIONS DUE TO MEDICAL CONTRAINDICATIONS.**

*The physical condition of the above named person is such that immunization would endanger life or health, or is medically contraindicated due to other medical conditions.*

_____ _____
*Signature of Medical Professional* *Date*

## HEALTH EXAMINATION – required within the past year (MUST be completed by your health care provider.)

*Exam required within the past year or if NCAA participant must be within six months of the first day of practice.*

Name: _____ Birth date: _____ / _____ / _____
*Last* *First* *Middle* *Month* *Day* *Year*

Height _____ Weight _____ Pulse _____ BP _____/_____

Corrected Vision: Rt 20/ _____ Lt 20/ _____ Pupils: Equal _____ Unequal _____ Hearing screen: Pass _____ Fail _____

| PHYSICAL EXAM: | NORMAL | ABNORMAL *(describe)* |
|---|---|---|
| Appearance: | | |
| Skin | | |
| Eyes, ears, nose, throat | | |
| Lymph nodes | | |
| Neck, thyroid | | |
| Heart/pulses | | |
| Lungs | | |
| Abdomen (include hernia) | | |
| Genitourinary | | |
| Neurological | | |
| Psychological | | |
| Musculoskeletal | | |

Is the student now under treatment for any medical or mental health condition? _____ No _____ Yes (specify) _____

_____

### ASSESSMENT / PLAN:

1. General health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
2. Immunizations Up To Date? ☐ Td/Tdap in past 10 years _____ / _____ / _____ ☐ MMR (one dose after 12 mo. of age.) _____ / _____ / _____
   *Month* *Day* *Year* *Month* *Day* *Year*

   ☐ Immunizations given or updated _____

   ☐ TB risk screened? YES / NO *(circle)*
3. Recommendation for physical activity (NCAA sports, club sports, intramurals, PE)
   ☐ Unlimited ☐ Limited ☐ Disqualified If limited, please specify _____
4. Examiner's comments/other recommendations: _____

   _____

### TUBERCULOSIS SCREENING

1. Does the student have signs or symptoms of active tuberculosis disease?
   ☐ Yes ☐ No
2. Is the student a member of a high-risk group? ☐ Yes ☐ No

***If Yes to either question above, please proceed with appropriate screening tests.**

### SICKLE CELL TRAIT SCREENING

**NCAA participants:** The NCAA Committee on Competative Safeguards and Medical Aspects of Sports is recommending that member institutions test student-athletes to confirm their Sickle Cell Trait status if that information is not already known.

1. Was the student screened for Sickle Cell Trait status?
   If yes, results _____

### SPECIAL NEEDS / DISABILITY

**Do you have a special need and/or a medical, physical or learning disability?** ☐ No ☐ Yes Please list: _____

**Would you like to be contacted by our resource person for students with disabilities?**

☐ No ☐ Yes, please forward my name and contact information.

_____ _____ Date: _____ / _____ / _____
*Print examiner's name:* *Examiner's signature* *Month* *Day* *Year*

Address: _____ Telephone: _____

_____

_____ FAX: _____

This person has been accepted at Gustavus Adolphus College. The information will not affect his/her status and will be used only as a background for providing health care.
No part of this record will be disclosed or released without written client permission.