INTERNATIONAL 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 <u>one month prior</u> 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: (_____) _____

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 _____
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

TB risk will be assessed upon arrival to Gustavus Adolphus College.

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.