

Health Form | 2008-2009

Due **July 1** for Fall Enrollment

Due **December 1** for Spring Enrollment

FOR HEALTH CENTER USE ONLY:

INCOMPLETE DUE TO:

Measles#1 ____ #2 ____

Tetanus ____ TB ____

Signature for TX Minor ____

or for Meningitis ____

Others _____

Received _____

COMPLETE ____

ENTERED ____

NOTIFICATIONS for deficiencies:

Valparaiso University Student Health Center

1406 LaPorte Ave., Valparaiso, IN 46383 | Phone: 219.464.5060 Fax: 219.464.5410 | Health.Center@valpo.edu | www.valpo.edu/health

IMPORTANT

- Health Forms are due on **July 1** for Fall enrollment and **December 1** for Spring enrollment, and must be completed in English.
- There is a \$50 charge for late or incomplete forms.
- All immunization requirements must be met before the form is considered complete.
- The Health Form must be signed by your health care provider, **OR** you must attach copies of your immunization records to the form.
- Remember to sign and date your form.
- Health Forms should be mailed directly to the Health Center at the address listed above.
- **Please call the Health Center at (219) 464-5060 if you need assistance completing your form.**

Name _____ Birth Date ____/____/____

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Email Address _____

SS# ____/____/____ Gender: Male Female

Enrollment Status: Part-time Full-time Undergraduate Law Grad Interlink International

Parent/Guardian/Spouse _____ Home Phone _____

Address _____ Work Phone _____

Emergency Contact/Name: _____ Relationship _____ Phone _____

IMMUNIZATION HISTORY *Required by the state of Indiana*

Documentation may be obtained from your health care provider or previous school records. If documentation is unavailable, re-immunization or a blood test (titer) to determine level of immunity is required. MMR not required if born before 1957.

The following immunizations **ARE MANDATORY** for students attending schools in the state of Indiana:

Tetanus/Diphtheria - received within the past 10 years.

2 MMRs fulfill requirements - two (2) doses; 1st dose after 12 months of age and the 2nd dose at least 28 days after first dose

OR **Measles** (rubeola) - two (2) doses; 1st dose after 12 months of age and the 2nd dose at least 28 days after first dose.

Mumps - one (1) dose received after 12 months of age.

Rubella (German / 3-day measles) - one (1) dose received after 12 months of age.

Tuberculin Skin Test Questionnaire

MANDATORY IMMUNIZATIONS	DATE RECEIVED Month/Day/Year	(May attach other documentation as proof of immunizations.)			RECOMMENDED IMMUNIZATIONS	DATE RECEIVED Month/Day/Year
MMR (Measles, Mumps & Rubella) 1st Dose 2nd Dose	____/____/____				HEPATITIS B 1st Dose 2nd Dose 3rd Dose	____/____/____
	____/____/____					____/____/____
	____/____/____					____/____/____
OR: (individual doses) MEASLES (Rubeola) 1st Dose 2nd Dose MUMPS RUBELLA	____/____/____	OR	TITER Copy of lab result must be attached	OR	HISTORY OF DISEASE Diagnosed by physician	HEPATITIS A 1st Dose 2nd Dose
	____/____/____					____/____/____
	____/____/____					MENINGITIS ____/____/____
	____/____/____					VARICELLA ____/____/____
TETANUS/ DIPHTHERIA	____/____/____	Must be within 10 years			OTHERS	____/____/____ ____/____/____ ____/____/____

Physician Name (print) _____ Physician Signature _____

Address _____ Office Phone _____ Exam Date _____

TUBERCULIN SKIN TEST (PPD) QUESTIONNAIRE is mandatory for ALL STUDENTS.

Please answer (Y) or (N). *TB testing is required for all students if any answers are 'yes' except #1. If so, please have health care provider complete Box A.*

1. Do you have medical documentation of a negative TB skin test given in the U.S.?
2. Were you born outside of the U.S. or are you *not* a U.S. citizen?
3. Have you ever had a positive TB skin test or been told that you have TB? If 'yes', but no documentation, testing is indicated.
4. Are you in any of the following high-risk categories:
 - Signs or symptoms of active tuberculosis: persistent cough; fever; bloody sputum; weight loss; night sweats; short of breath; chest pain
 - HIV infection
 - Close contact of person with infectious TB
 - IV/injected drug use
 - Resided, employed, volunteer in: prisons/jails; nursing homes/long-term care facilities; hospitals/other health care facilities;
 - residential facilities for AIDS patients; homeless shelters
 - Chronic illness/condition (Diabetes, silicosis, renal failure, leukemia/lymphoma, malignancy/cancer, low body weight, gastrocomy/jejunal bypass, prolonged corticosteroid therapy, immunosuppressive therapy, abnormal chest x-ray)
5. Are you studying to go into the health care field?

A. INTERNATIONAL STUDENTS AND THOSE WHO ANSWERED 'YES' TO QUESTIONS 2-5: TB (PPD) TESTING IS REQUIRED. Test must be completed in the United States within the last year. Signature and address of Health Care Provider must be completed as proof. This test may be performed at Health Center upon arrival to campus.

TB (PPD) SKIN TEST Date Administered: ____/____/____ Date Test Read: ____/____/____	Signature of Health Care Provider _____ mm	SKIN TEST RESULT (Size of induration) _____ mm	CHEST X-RAY Required if TB skin test is positive DATE OF X-RAY: ____/____/____ RESULT: NEG POS	Attach copy of written report _____	Health Care Provider: Signature of Health Care Provider _____ Print Provider's Name _____ Address _____ Phone _____	TREATMENT (if any)
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I HAVE READ AND UNDERSTAND THE IMMUNIZATION REQUIREMENTS OF THIS FORM AND THE ENCLOSED MENINGITIS INFORMATION SHEET. This form has been truthfully completed to the best of my knowledge and I freely consent to this form being used for my treatment at the Valparaiso University Health Center.

PERMISSION FOR TREATMENT: I/We hereby grant permission to the physician and staff of the Valparaiso University Student Health Center, and any hospital, surgical, or psychiatric facility for treatment as deemed necessary by any one of them for the above named student. In addition, if I receive treatment at Porter Hospital while a student at Valpo, I give Porter Hospital and all its departments consent for release of information to Valparaiso University Student Health Center. I will be responsible for payment of those charges to Valparaiso University. I affirm that the information present on this Health Form is complete and accurate to the best of my knowledge.

Students' Signature _____ Date _____

Parents'/Guardians' Signature (if under 18) _____ Relationship _____

HEALTH HISTORY

No Significant Medical History	Allergies to Medications please list	Other Significant Allergies (e.g. foods, bee stings, etc)	Routine Prescription Drugs
<input type="checkbox"/>			

Check all applicable conditions and provide details below:

- Abnormal Pap Smear
- Anesthesia Reactions
- Anemia
- Anxiety
- Arthritis
- Bleeding Tendency
- Colitis/Irritable Bowel Syndrome
- Depression
- Diabetes
- Disabling Loss of Vision/Hearing
- Eating Disorders
- (Anorexia, Bulimia, Obesity)
- Head Injury
- Headaches/Migraines
- Heart Disease/Abnormality
- Hepatitis/Jaundice
- High Blood Pressure
- Hospitalization:
- Medical
- Psychiatric
- Immune Disorders
- Infectious Mononucleosis
- Kidney/Urinary Problems
- Rheumatic Fever
- Seizure Disorder/Convulsions
- Surgeries (explain below)
- Thyroid Disease
- Tuberculosis
- Tumor: Benign/Malignant (explain below)
- Ulcer
- Undescended Testicle, Mass, Lump
- Other, describe _____

Please provide details of history noted above. Have your health care provider identify any problems that require ongoing or follow-up care by Health Center, with their recommendation. Please attach pertinent information and/or medical records.

PHYSICAL EXAMINATION

A Physical Exam is REQUIRED for all ATHLETES and strongly recommended for any students who plan to participate in on-campus activities, travel, or study abroad. Form to be completed by health care provider.

Name	Date of Birth	Age
Height	Weight	Blood Pressure
Vision	R 20/	L 20/
	Corrected:	Y N

MEDICAL	NORMAL	ABNORMAL FINDINGS	COMMENTS
Appearance (Marfan's)			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart (Supine & Standing)			
Pulses			
Lungs			
Abdomen			
Genitalia/Hernia			
Skin			
Neurological			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Clearance:

- A. Cleared
- B. Cleared after completing evaluation/rehabilitation for: _____
- C. Not cleared

Due to: _____

Recommendations: _____

I hereby certify that this athlete was examined by me. At that time, no physical condition was detected which would reasonably be anticipated to render this athlete unfit to engage in any sport.

Name of Physician _____ Date _____

Address _____ Phone _____

Signature of Physician _____

VALPARAISO UNIVERSITY ATHLETE PRE-PARTICIPATION QUESTIONNAIRE

Questionnaire to be completed by student-athletes only.

SPORT:

Explain "Yes" answers below:

YES NO

1. Have you ever been hospitalized? YES NO

Have you ever had surgery? YES NO

Are you presently under a doctor's care? YES NO

2. Have you ever passed out during or after exercise? YES NO

Have you ever felt dizzy during or after exercise? YES NO

Have you ever had chest pain during or after exercise? YES NO

Have you ever had high blood pressure? YES NO

Have you ever been told you have a heart murmur? YES NO

Have you ever had racing of your heart or skipped heartbeats? YES NO

Has anyone in your family died of heart problems or sudden death before age 50? YES NO

Has anyone in your family had Marfan's syndrome? YES NO

3. Do you have any skin problems (itching, rashes, acne)? YES NO

4. Have you ever had a head injury? YES NO

Have you been knocked out or unconscious? YES NO

Have you ever had a seizure or epilepsy? YES NO

5. Have you ever had heart cramps, heart illness or muscle cramps? YES NO

6. Do you have trouble breathing or do you cough during or after activity? YES NO

7. Do you use any special equipment (pads, braces, neck rolls, eye guards, etc.)? YES NO

8. Have you had any problems with your eyes or vision? YES NO

Do you wear glasses or contacts or protective eye wear? YES NO

9. Are you missing an eye, kidney or testicle? YES NO

10. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints? YES NO

Head Shoulder Thigh Neck Elbow Knee Foot

Forearm Shin/Calf Back Wrist Ankle Hip Hand

11. Have you had any other medical problems (infectious mononucleosis, diabetes, anemia, etc.)? YES NO

12. Have you had a medical problem or injury since your last evaluation? YES NO

13. When was your first menstrual period? _____

When was your last menstrual period? _____

What was the longest time between your periods last year? _____

14. Family History:

- Arthritis
- Cancer
- Diabetes
- Epilepsy
- Sickle Cell
- Ulcers
- Hemophilia
- Heart Disease

Explain "Yes" answers/check marks: _____

I hereby state that, to the best of my knowledge, my answers to the above questionnaire are correct.

Signature of Athlete _____

Date _____