

Health Form | 2009-2010

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

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, gastrectomy/jejunoileal 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.*

TB (PPD) SKIN TEST Date Administered: ____ / ____ / ____ Date Test Read: ____ / ____ / ____	Skin Test Result (Size of induration) _____ mm Signature of Health Care Provider	CHEST X-RAY <small>Required if TB skin test is positive</small> ____ / ____ / ____ DATE OF X-RAY RESULT: NEG POS Attach copy of written report	Health Care Provider: _____ <small>Signature of Health Care Provider</small> _____ <small>Print Provider's Name</small> _____ <small>Address</small> _____ <small>Phone</small>	TREATMENT (if any)
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HEALTH HISTORY

No Significant Medical History	Allergies to Medications <small>please list</small>	Other Significant Allergies <small>(e.g. foods, bee stings, etc)</small>	Routine Prescription Drugs
<div style="border: 2px solid blue; width: 40px; height: 40px; margin: 0 auto;"></div>			

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 recommendations. Please attach pertinent information and/or medical records.

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, medical, 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, and in the case of psychiatric emergency, the Student Counseling 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.

Student's Signature _____ **Date** _____

Parent's/Guardian's Signature (if under 18) _____ **Relationship** _____

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 _____ Pulse _____

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 heat cramps, heat 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 _____