Valparaiso University | Health Center

FOR HEALTH CENTER USE ONLY:

Received _____

INCOMPLETE DUE TO:

Measles #1 _____ #2 _____
Tetanus _____ TB _____
Others _____

COMPLETE _____ **ENTERED** _____

Signature for TX Minor _____
or for Meningitis _____

Health Form

DEADLINES:

July 1 for Fall Undergraduate Enrollment
August 1 for Graduate/Law Students
December 1 for Spring Undergraduate Enrollment

IMPORTANT

- All forms 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, 1406 LaPorte Ave., Valparaiso, IN 46383.
- Please call the Health Center at **219.464.5060** if you need assistance completing your form.

Which semester will you be attending? ❍ Fall ❍ Spring ❍ Summer

Last Name _____ First Name _____ Birth Date _____/_____/_____ (M D Y)

Home Street Address _____

City _____ State _____ Zip _____ Country _____

Home Phone _____ Cell Phone _____

E-mail Address _____ Valpo ID # _____ Gender: ❍ Male ❍ Female

Enrollment Status **(CHECK ALL THAT APPLY)**: ❍ Part-time ❍ Full-time ❍ Undergraduate ❍ Law ❍ Grad ❍ Interlink ❍ International

Parent/Guardian/Spouse _____ Home Phone _____

Address _____ Work Phone _____

Emergency Contact/Name _____ Relationship _____ Phone _____

Health History

Valparaiso University | Health Center

Student Name: _____ Birth Date _____/_____/_____
M D Y

No Significant Medical History	Allergies to Medications please list	Other Significant Allergies (e.g., foods, bee stings, gluten, etc.)	Routine Prescription Drugs
☐			

Check all applicable conditions and provide details below:

____ Abnormal Pap Smear
____ ADHD/ADD
____ Allergy (Food, Environmental, Medical)
____ Anesthesia Reactions
____ Anemia
____ Anxiety
____ Arthritis
____ Asthma
____ Bleeding Tendency
____ Celiac Disease (Gluten Intolerance)
____ Colitis/Irritable Bowel Syndrome
____ Depression
____ Diabetes
____ Disabling Loss of Vision/Hearing

____ Eating Disorder (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, please 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.

Required Student's Signature _____ **Date** _____

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

Student Name: _____ Birth Date _____/_____/_____
M D Y

DEADLINES:

July 1 for Fall Undergraduate Enrollment • **August 1** for Graduate/Law Students • **December 1** for Spring Undergraduate Enrollment

IMPORTANT

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- 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, 1406 LaPorte Ave., Valparaiso, IN 46383.
- Please call the Health Center at **219.464.5060** if you need assistance completing your form.

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.

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER OR ATTACH OFFICIAL IMMUNIZATION RECORD FROM PREVIOUS SCHOOL, HEALTH DEPARTMENT OR PHYSICIAN.

All information must be in English. If documentation is unavailable, re-immunization or a blood test (titre) to determine immunity is required. MMR is not required if you were born before 1956.

Required Immunizations

M.M.R. (Measles, Mumps, Rubella) (Two doses required at least 28 days apart for students born after 1956 and all health science students.)

Dose 1 given at age 12 months or later	#1 _____/_____/_____ (M D Y)
Dose 2 given at least 28 days after first dose	#2 _____/_____/_____ (M D Y)
OR positive MMR antibody titre indicating immunity **(copy of lab report must be attached)**	Date: _____/_____/_____ (M D Y) Immune ❍ Not Immune ❍
OR history of disease diagnosed by physician	Yes ❍ No ❍

Tetanus-Diptheria-Pertussis

(Primary series with DTaP, DTP, DT, or Td, and booster with Td or Tdap in the last ten years. Health sciences students with patient contact should receive one dose of Tdap at an interval as short as 2 years since last Td as appropriate. Refer to ACIP for details.)

Primary series of four doses with DTaP, DTP, DT, or Td:

#1 _____/_____/_____ #2 _____/_____/_____ #3 _____/_____/_____ #4 _____/_____/_____ #5 _____/_____/_____
(M D Y) (M D Y) (M D Y) (M D Y) (M D Y)

Booster: Tdap (preferred) to replace a single dose of Td for booster immunization at least 2-5 years since last dose of Td, depending on age of patient. (Administer with MCV4 simultaneously, if possible.)

Tdap Booster: _____/_____/_____ (M D Y)

Td Booster within the **LAST TEN YEARS**: _____/_____/_____ (M D Y)

Health Care Provider Name _____ Address _____

Health Care Provider Signature _____ Phone _____

Recommended Immunizations:
(Not Required)

Valparaiso University | Health Center

Student Name: _____ Birth Date _____/_____/_____ (M D Y)

Meningococcal Tetravalent
(A, C, Y, W-135/One dose for college freshman living in dormitories/residence halls, persons with asplenia, travelers to endemic areas, non-freshman college students who wish to reduce their risk of meningococcal disease.)

Tetravalent conjugate (preferred; administer simultaneously with Tdap if possible):	_____/_____/_____ (M D Y)
Tetravalent polysaccharide(acceptable alternative if conjugate not available; revaccinate every 3-5 years if increased risk continues):	_____/_____/_____ (M D Y)

Polio **(Primary series, doses started at 28 days apart. Three primary series acceptable.)**

OPV / IPV (circle one [1] only)

OPV/ IPV #1 _____/_____/_____ (M D Y) OPV/ IPV #2 _____/_____/_____ (M D Y) OPV/ IPV #3 _____/_____/_____ (M D Y) OPV/ IPV #4 _____/_____/_____ (M D Y)

Hepatitis A

Dose #1 _____/_____/_____ (M D Y) Dose #2 _____/_____/_____ (M D Y)

Hepatitis A & B

Dose #1 _____/_____/_____ (M D Y) Dose #2 _____/_____/_____ (M D Y) Dose #3 _____/_____/_____ (M D Y)

Hepatitis B (All health science students. Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age, or a positive hepatitis B surface antibody meets the requirements)

Dose #1 _____/_____/_____ (M D Y) Dose #2 _____/_____/_____ (M D Y) Dose #3 _____/_____/_____ (M D Y)

OR Hepatitis B surface antibody

Date: _____/_____/_____ (M D Y) Result: Reactive ❍ Non-Reactive ❍

Varicella
(Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meet the requirement)

History of the disease? Yes ❍ No ❍

Varicella Antibody: _____/_____/_____ (M D Y)	Result: Reactive ❍ Nonreactive ❍
Immunization: Dose #1 _____/_____/_____ (M D Y)	Immunization: Dose #2 _____/_____/_____ (M D Y)

Quadrivalent Human Papillomavirus Vaccine (HPV)
(Three doses of vaccine for college students 11-26 years of age at 0, 2, and 6 month intervals)

Dose #1 _____/_____/_____ (M D Y) Dose #2 _____/_____/_____ (M D Y) Dose #3 _____/_____/_____ (M D Y)

Pneumococcal Polysaccharide Vaccine
(One dose recommended for members in high-risk groups)

Date: _____/_____/_____ (M D Y)

Influenza Vaccine

Annual immunization recommended to avoid influenza complications in high-risk patients, to avoid influenza complications in high-risk patients, to avoid disruption to academic activities, and to limit transmission to high-risk individuals. Health science students with patient contact.
The Health Center offers influenza vaccine to students for a nominal fee beginning in September each year, when supplies become available.

Health Care Provider Name _____ Address _____

Health Care Provider Signature _____ Phone _____

Student Name: _____ Birth Date _____/_____/_____
M D Y

Tuberculosis (TB) Screening/Testing

Student please answer the following questions:

Have you ever had a positive TB skin test? Yes ❍ No ❍

Have you ever had close contact with anyone who was sick with TB? Yes ❍ No ❍

Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years?* Yes ❍ No ❍
(If yes, the International Statement (see box on next page) will pertain to you. Please circle the country of birth.

Have you **EVER** traveled ** to/in one or more of the countries listed below? Yes ❍ No ❍ Length of time _____
(If yes, please check the country/ies) (Was this a cruise or vacation?)

Have you ever been vaccinated with BCG? Yes ❍ No ❍

* Future CDC updates may eliminated the 5-year time frame.
** The significance of the travel exposure should be discussed with a health care provider and evaluated.

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bahamas
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia & Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Rep.
Chad
China
Colombia
Comoros
Congo
Cong DR
Cote d'Ivoire
Croatia
Djibouti
Dominican Republic
Ecuador
Egypt
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran
Iraq
Japan
Kazakhstan
Kenya
Kiribati
Korea-DPR
Korea-Republic
Kuwait
Kyrgyzstan
Lao PDR
Latvia
Lesotho
Liberia
Lithuania
Macedonia-TFYR
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia
Moldova-Rep.
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Niue
N. Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Romania
Russian Federation
Rwanda
St. Vincent & The Grenadines
Sao Tome & Principe
Saudi Arabia
Senegal
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Spain
Sri Lanka
Suriname
Syrian Arab Republic
Swaziland
Tajikistan
Tanzania-UR
Thailand
Timore-Leste
Togo
Tokelau
Tonga
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela
Viet Nam
Wallis & Futuna Islands
W. Bank & Gaza Strip
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Tuberculosis Control, WHO Report 2006, Countries with Tuberculosis incidence rates of >20 cases per 100,000 population.
For future updates, refer to www.who.int/globalatlas/dataQuery/default.asp.

If the answer is YES to any of the above questions, Valparaiso University requires that a health care provider complete a tuberculosis risk assessment (to be completed within 6 months prior to the start of classes).

If the answer to all of the above questions is NO, no further testing or further action is required.

The American College Health Association has published guidelines on "Tuberculosis Screening and Targeted Testing of College and University Students."
To obtain the guidelines, visit www.acha.org.

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

Required Student's Signature _____

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

Student Name: _____ Birth Date _____/_____/_____
M D Y

Tuberculosis (TB) Risk Assessment – TO BE COMPLETED BY HEATH CARE PROVIDER

Persons with any of the following risk factors are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented:

Recent close contact with someone with infectious TB disease: Yes ❍ No ❍

Foreign-born from (or travel* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America): Yes ❍ No ❍

Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease: Yes ❍ No ❍

HIV/AIDS: Yes ❍ No ❍

Organ transplant recipient: Yes ❍ No ❍

Immunosuppressed (equivalent of >15 mg/day of prednisone for >1 month or TVF-a antagonist): Yes ❍ No ❍

History of illicit drug use: Yes ❍ No ❍

Resident, employee, or volunteer in a high-risk congregate setting
(e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities): Yes ❍ No ❍

Medical condition associated with increase risk of progressing to TB disease if infected (e.g., diabetes mellitus, silicosis, head, neck, or lungh cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal for the given population) Yes ❍ No ❍

Does the student have signs or symptoms of active tuberculosis disease? Yes ❍ No ❍

If you answered YES to any of the questions above, the student must complete one of the tests below.

ALL INTERNATIONAL STUDENTS: If you are from one of the countries listed on the previous page, you must provide proof of a negative test. If you are tested before arrival in the United States, you must show proof of a negative Intefron Gama Release Assay (IGRA) or normal chest x-ray. A negative Tuberculin skin test is acceptable if completed in the United States.

***NOTE: A TB TEST, AS DESCRIBED ABOVE, IS REQUIRED EVERY TIME THE STUDENT VISITS ANY OF THE LISTED COUNTRIES ON THE PREVIOUS PAGE.**

1. **interferon Gama Release Assay (IGRA) MAY BE DONE IN NATIVE COUNTRY.**

   Date Obtained: _____/_____/_____ (specify method) QFT-G QFT-GIT other _____
   M D Y

   Result: Positive ❍ Negative ❍ Intermediate ❍

2. **Chest x-ray: (Required if TST or IGRA is positive) MAY BE DONE IN NATIVE COUNTRY.**

   Date of chest x-ray: _____/_____/_____ Result: Normal ❍ Abnormal ❍
   M D Y

3. **Tuberculin Skin Test (TST) Must be done and read in the United States.** (TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0." The TST interpretation should be based on mm of induration as well as risk factors.)**

   Date Given: _____/_____/_____ Date Read: _____/_____/_____
   M D Y M D Y

   Result: _____ mm of induration **Interpretation: Positive ❍ Negative ❍

****Interpretation guidelines**

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
- Organ transplant recipients
- Immunosuppressed persons: taking > 15 mg/d of prednisone for > 1 month; taking a TNF-a antagonist
- Persons with HIV/AIDS

**The significance of the exposure should be discussed with a health care provider and evaluated.*

> 10 mm is positive:

- Persons born in a high prevalence country or who resided in one for a significant* amount of time
- History of illicit drug use
- Mycobacteriology laboratory personnel
- History of resident, worker or volunteer in high-risk congregate settings
- Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes

>15 mm is positive:

- Persons with no known risk factors for TB disease

Health Care Provider Name _____ Address _____

Health Care Provider Signature _____ Phone _____

VALPARAISO UNIVERSITY ATHLETE PRE-PARTICIPATION QUESTIONNAIRE

Questionnaire to be completed by student-athletes only.

Sport: _____ Student Name: _____ Birth Date: _____/_____/_____ (M D Y)

Explain "Yes" answers below:	YES	NO
1. Have you ever been hospitalized?	❍	❍
Have you ever had surgery?	❍	❍
Are you presently under a doctor's care?	❍	❍
2. Have you ever passed out during or after exercise?	❍	❍
Have you ever felt dizzy during or after exercise?	❍	❍
Have you ever had chest pain during or after exercise?	❍	❍
Have you ever had high blood pressure?	❍	❍
Have you ever been told you have a heart murmur?	❍	❍
Have you ever had racing of your heart or skipped heartbeats?	❍	❍
Has anyone in your family died of heart problems or sudden death before age 50?	❍	❍
Has anyone in your family had Marfan's syndrome?	❍	❍
3. Do you have any skin problems (itching, rashes, acne)?	❍	❍
4. Have you ever had a head injury?	❍	❍
Have you been knocked out or unconscious?	❍	❍
Have you ever had a seizure or epilepsy?	❍	❍
5. Have you ever had heat cramps, heat illness or muscle cramps?	❍	❍
6. Do you have trouble breathing or do you cough during or after activity?	❍	❍
7. Do you use any special equipment (pads, braces, neck rolls, eye guards, etc.)?	❍	❍
8. Have you had any problems with your eyes or vision?	❍	❍
Do you wear glasses or contacts or protective eye wear?	❍	❍
9. Are you missing an eye, kidney or testicle?	❍	❍
10. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints?	❍	❍

❍ 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.)?	❍	❍
12. Have you had a medical problem or injury since your last evaluation?	❍	❍

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: _____

15. Have you had a Sickle Cell screening blood test?	❍	❍
If No, have you signed a waiver in the athletic department	❍	❍

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

Signature of Athlete _____ Date _____

Physical Examination
FOR STUDENT ATHLETES

Valparaiso University | Health Center

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 and Standing)			
Pulses			
Lungs			
Abdomen			
Genitalia/Hernia			
Skin			
Neurological			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

❑ Sickle Cell Screening blood test ❑ Sickle Cell waiver (This waiver is available on the Health Center website: **valpo.edu/healthcenter**)

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 that would reasonably be anticipated to render this athlete unfit to engage in any sport.

Name of Health Care Provider _____ Date _____

Address _____ Phone _____

Signature of Health Care Provider _____