Return to:
Gustavus Adolphus College
Student Health Service
800 West College Avenue | St. Peter, MN 56082

PHONE 507-933-7630
FAX 507-933-6074
E-mail health-service@gustavus.edu

Student ID#

MUST BE FILLED OUT IN ENGLISH and COMPLETED IN INK

STUDENT HEALTH HISTORY FORM

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

CONFIDENTIAL (To be completed by student)

Name: ______ (Last) ______ (First) ______ (Middle) Birth date: ___ / ___ / ___ (Month / Day / Year)

First name preference: ______ ☐ Male ☐ Female

Permanent address: ______ City: ______

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

Cell phone: (____) ______

Social security number: |__|__|__| - |__|__| - |__|__|__|__| E-mail: ______

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

Cell phone: (____) ______ Work phone: (____) ______

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

Cell phone: (____) ______ Work phone: (____) ______

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

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.*

______ *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: ______________________________ (Last / First / Middle) Birth date: ______ / ______ / ______ (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. ______ / ______ / ______ (Month / Day / Year) 2. ______ / ______ / ______ (Month / Day / Year)

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

RECOMMENDED IMMUNIZATIONS

Meningitis 1. ______ / ______ / ______ (Month / Day / Year) ☐ Menomune, or ☐ Menactra?

Hepatitis A 1. ______ / ______ / ______ (Month / Day / Year) 2. ______ / ______ / ______ (Month / Day / Year)

Hepatitis B 1. ______ / ______ / ______ (Month / Day / Year) 2. ______ / ______ / ______ (Month / Day / Year) 3. ______ / ______ / ______ (Month / Day / Year)

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

Examiner: Review the family and personal history and immunization record; complete this form and update any immunizations.

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 _____ / _____ / _____ (*Month* *Day* *Year*) ☐ MMR (one dose after 12 mo. of age.) _____ / _____ / _____ (*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
   If No, proceed to 2. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.
2. Is the student a member of a high-risk group or is the student entering the health profession? ☐ Yes ☐ No
   If No, stop. If Yes, perform tuberculin skin test (Mantoux). A history of BCG vaccination should not preclude testing of a member of a hish-risk group.

SPECIAL NEEDS / DISABILITY

Do you have a special need or 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.