

Health Form | 2011-2012

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

FOR HEALTH CENTER USE ONLY: Received _____

INCOMPLETE DUE TO: _____

Measles #1 _____ #2 _____

Tetanus _____ TB _____

Signature for TX Minor _____

or for Meningitis _____

Others _____

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 | valpo.edu/health

IMPORTANT

- Health Forms are due on **July 1** for fall undergraduate enrollment, **August 1** for Graduate/Law Students and **December 1** for spring undergraduate 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 _____ E-mail 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.

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:

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

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 _____

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 female college students 11-26 years of age at 0, 2, and 6 month intervals)

Dose #1 ___/___/___ Dose #2 ___/___/___ Dose #3 ___/___/___
M D Y M D Y 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 _____

Signature _____ Phone _____

RECOMMENDED

Tuberculosis (TB) Screening/Testing

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, please circle the country)

Have you ever traveled ** to/in one or more of the countries listed below? Yes No
(If yes, please check the country/ies)

Have you ever been vaccinated with BCG? Yes No

* Future CDC updates may eliminate the 5-year time frame.

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

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

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

Tuberculosis (TB) Risk Assessment - To be completed by Health 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 TNF- α 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 lung 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

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

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

If No, proceed to 2 or 3. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. 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

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

Result: ____ mm of induration **Interpretation: Positive Negative

INTERNATIONAL STUDENTS: If you choose to have a tuberculin skin test done in your native country and it is NEGATIVE, the test will need to be repeated in the United States. If you choose to have a tuberculin skin test done in your native country and it is POSITIVE, you will need to provide documentation of a negative chest x-ray (physician attestation or an X-ray report in English.

3. Interferon Gamma 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

Date Obtained: (specify method) QFT-G QFT-GIT other ____

Result: Positive Negative Intermediate

4. 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

**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- α antagonist
- Persons with HIV/AIDS

> 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

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

Health Care Provider

Name: _____ Address: _____

Signature: _____ Phone: _____

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? | <input type="radio"/> | <input type="radio"/> |
| Have you ever had surgery? | <input type="radio"/> | <input type="radio"/> |
| Are you presently under a doctor's care? | <input type="radio"/> | <input type="radio"/> |
| 2. Have you ever passed out during or after exercise? | <input type="radio"/> | <input type="radio"/> |
| Have you ever felt dizzy during or after exercise? | <input type="radio"/> | <input type="radio"/> |
| Have you ever had chest pain during or after exercise? | <input type="radio"/> | <input type="radio"/> |
| Have you ever had high blood pressure? | <input type="radio"/> | <input type="radio"/> |
| Have you ever been told you have a heart murmur? | <input type="radio"/> | <input type="radio"/> |
| Have you ever had racing of your heart or skipped heartbeats? | <input type="radio"/> | <input type="radio"/> |
| Has anyone in your family died of heart problems or sudden death before age 50? | <input type="radio"/> | <input type="radio"/> |
| Has anyone in your family had Marfan's syndrome? | <input type="radio"/> | <input type="radio"/> |
| 3. Do you have any skin problems (itching, rashes, acne)? | <input type="radio"/> | <input type="radio"/> |
| 4. Have you ever had a head injury? | <input type="radio"/> | <input type="radio"/> |
| Have you been knocked out or unconscious? | <input type="radio"/> | <input type="radio"/> |
| Have you ever had a seizure or epilepsy? | <input type="radio"/> | <input type="radio"/> |
| 5. Have you ever had heat cramps, heat illness or muscle cramps? | <input type="radio"/> | <input type="radio"/> |
| 6. Do you have trouble breathing or do you cough during or after activity? | <input type="radio"/> | <input type="radio"/> |
| 7. Do you use any special equipment (pads, braces, neck rolls, eye guards, etc.)? | <input type="radio"/> | <input type="radio"/> |
| 8. Have you had any problems with your eyes or vision? | <input type="radio"/> | <input type="radio"/> |
| Do you wear glasses or contacts or protective eye wear? | <input type="radio"/> | <input type="radio"/> |
| 9. Are you missing an eye, kidney or testicle? | <input type="radio"/> | <input type="radio"/> |
| 10. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints? | <input type="radio"/> | <input type="radio"/> |

- | | | | | | | |
|-------------------------------|---------------------------------|-----------------------------|-----------------------------|-----------------------------|----------------------------|----------------------------|
| <input type="radio"/> Head | <input type="radio"/> Shoulder | <input type="radio"/> Thigh | <input type="radio"/> Neck | <input type="radio"/> Elbow | <input type="radio"/> Knee | <input type="radio"/> Foot |
| <input type="radio"/> Forearm | <input type="radio"/> Shin/Calf | <input type="radio"/> Back | <input type="radio"/> Wrist | <input type="radio"/> Ankle | <input type="radio"/> Hip | <input type="radio"/> 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:

- | | | | |
|-----------------------------------|------------------------------|----------------------------------|-------------------------------------|
| <input type="radio"/> Arthritis | <input type="radio"/> Cancer | <input type="radio"/> Diabetes | <input type="radio"/> Epilepsy |
| <input type="radio"/> Sickle Cell | <input type="radio"/> Ulcers | <input type="radio"/> Hemophilia | <input type="radio"/> 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 _____

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

Name of Physician _____ Date _____

Address _____ Phone _____

Signature of Physician _____



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