NEW STUDENT MEDICAL HISTORY AND PHYSICAL EXAMINATION

Lawrence University Health Services • 711 E. Boldt Way • Appleton, WI 54911-0599 • Phone: 920-832-6574 • Fax: 920-832-7488

Wisconsin law states that you must have this form completed with an accurate immunization history **BEFORE** you will be allowed to register for classes during Welcome Week web registration.

First name: _____ MI: ____ Last name: _____ LU ID: _____

Date of birth: ____/____/_____ Age: ___ Gender identity: _____ Preferred pronoun: _____ Class: Fr So Jr Sr

Home address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Date form completed: ____/____/_____

INSTRUCTIONS:

1. Complete Part I (sections A-D) before physical exam and then take it with you to your physical exam.
2. Part II **MUST** be filled out by a healthcare provider.
3. Make sure all forms are signed by you (or parent/guardian if under 18) AND by healthcare provider where indicated.
4. Please attach a copy of your insurance card(s) **FRONT AND BACK**. ***Check here if uninsured:*** □
5. This form must be filed with University Health Services by **August 1**.
6. If you are participating in Lawrence University Varsity Athletics, please indicate your sport here: _____

PART I ---- MEDICAL HISTORY

A. Immunizations-date of **MOST RECENT** immunization or active disease.*

*Please attach a copy of immunication record provided by Health Care Provider.

- Measles, Mumps, Rubella - TWO DOSES REQUIRED to be able to reside in University housing.
- Tetanus immunization within the past ten years is recommended.

REQUIRED – dates must be included (you cannot register for classes without the state required immunizations)				
1	Tetanus, Diphtheria, Pertussis (Tdap)	Last Dose: / /	Chicken pox (if you have not had the disease) and meningitis vaccinations are strongly recommended.	
2	Polio	Last Dose: / /		
3	Measles	Dose 1: / /	Dose 2: / /	
4	Mumps	Dose 1: / /	Dose 2: / /	
5	Rubella	Dose 1: / /	Dose 2: / /	
6	Hepatitis B or blood panel results:	Dose 1: / /	Dose 2: / /	Dose 3: / /
			(This series may be started at home and completed at Lawrence University)	
OPTIONAL				
1	BCG *(if not born in USA)*	Dose 1: / /		
2	Chicken Pox **(check box if you had the disease: □)**	Dose 1: / /	Dose 2: / /	
3	Meningitis	Dose 1: / /	Dose 2: / /	
4	Human Papillomavirus (HPV)	Dose 1: / /	Dose 2: / /	Dose 3: / /
5	Other (Typhoid, Hepatitis A, etc)			

B. Medications - Please list current medications and supplements, prescription and over the counter.

1.	4.
2.	5.
3.	6.

C. Allergies - Please indicate which allergies you have and explain reactions below.

Aspirin / Anti-Inflammatories	□Yes	□No	Reaction:
Codeine	□Yes	□No	Reaction:
Hay Fever / Seasonal	□Yes	□No	Reaction:
Insect Stings / Bites	□Yes	□No	Reaction:
Latex	□Yes	□No	Reaction:
Penicillin	□Yes	□No	Reaction:
Sulfa	□Yes	□No	Reaction:
Any Foods	□Yes	□No	Reaction:
Other:	□Yes	□No	Reaction:

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D. Medical History - Explain "Yes" answers below. Circle any questions you don't know the answer to.

FAMILY HISTORY – Has anyone in your immediate family experienced any of the following?

	Yes	No		Yes	No
Abnormal Heart Rate/Palpitation			Heart Murmur		
Blood Disorder			High Blood Pressure/Hypertension		
Diabetes			Marfan Syndrome		
Epilepsy			Psychiatric Illness		
Heart Disease/Heart Attack			Sudden Death (before 50)		

PERSONAL HISTORY – Have you ever experienced or do you currently have any of the following conditions?

	Yes	No		Yes	No
ADD/ADHD			Hearing Impairment/Loss or Ear Problems		
Anemia			Physical Handicap		
Asthma/Breathing Problems			Skin Conditions (ie: rash, acne, warts, infections)		
Autism/Aspergers			Syndrome Sleep Disorder		
Diabetes (Type I or II)			Tested positive for Sickle-Cell Trait or Disease		
Eating Disorder			Tumor/Growth/Cancer/Cyst		
Emotional Disturbance (Anxiety/Depression)			Visual Impairment/Loss or Eye Problems		
Emotional Trauma			Other:		

GENERAL QUESTIONS	Yes	No
1. Medical illness or injury since last check-up?		
2. Chronic illness or condition?		
3. Ever hospitalized overnight?		
4. Ever had surgery?		
5. Doctor ever denied/restricted sports participation?		
HEART HEALTH QUESTIONS	**Yes**	**No**
6. Ever passed out/ lightheaded/dizzy during or after exercise?		
7. Ever had chest pain during or after exercise?		
8. Heart race or skip beats during exercise?		
9. High blood pressure or high cholesterol?		
10. Heart murmur?		
11. Do you tire more quickly than peers during exercise?		
12. Severe viral infection (myocarditis, mononucleosis, etc)?		
MEDICAL QUESTIONS	**Yes**	**No**
13. Born without/are missing kidney, eye, spleen, other organ?		
14. Cough/wheeze/trouble breathing during or after activity?		
15. Head injury/concussion? (If so, how many and when?)		
16. Ever knocked out, become unconscious, lost memory?		
17. Ever had a stinger or a burner?		
18. Ever had a seizure?		
19. Ever had numbness/tingling in arms, hands, legs or feet?		
20. Frequent or severe headaches?		
21. Ever become ill from exercising in the heat?		
22. Wear glasses, contacts or protective eyewear?		
23. Wear dental appliances?		
24. Worry about your weight?		
25. Special diet? Avoid certain foods?		
26. Significant weight change recently?		

BONE AND JOINT QUESTIONS	Yes	No
27. Use any equipment or devices not usually used for your sport or position (pads, braces, neck roll, orthotics, mouth guard, etc)?		
28. Have a pin, screw or plate in your body?		
29. Ever had a stress fracture?		
30. Ever had an injury that required x-ray, MRI, CT scan, brace, cast or crutches?		

If yes to the following questions, check appropriate body part and explain:

31. Ever broken/fractured any bones / dislocated or sublexed joints?		
32. Ever had a sprain, strain or swelling after injury?		
33. Ever had other problems with pain or swelling in muscles, tendons, bones or joints?		

□ Head	□ Neck	□ Spine
□ Chest	□ Back	□ Shoulder
□ Upper Arm	□ Elbow	□ Forearm
□ Wrist	□ Hand	□ Back
□ Hip	□ Thigh	□ Knee
□ Shin/Calf	□ Ankle	□ Foot

EXPLAIN ANY "YES" ANSWERS BELOW:

34. Any concerns you wish to discuss with a doctor? □ Yes □ No

If you are/become a student-athlete, you also understand and agree that the Lawrence University Athletics Department will have access to this information. I hereby certify that, to the best of knowledge, the information provided on this form is complete and correct.

Signature of Student _____ Date _____ /_____ /_____

STANDING CONSENT FOR ROUTINE TREATMENT OF MINORS

I, the undersigned parent/guardian of the above named student, hereby give my consent for the provision of routine health care to said child by health care providers & staff of Lawrence University Health & Counseling Services. This care may be routine diagnostic procedures, examinations, medical treatment, routine laboratory tests, X-rays, health & wellness counseling, and the administration of prescribed medication. This consent shall be valid for the period of time commencing on the date of student arrival on campus until the student's 18th birthday. I do hereby indemnify and hold harmless the health care providers and entities and other persons who act in reliance upon this consent. I also authorize treatment by a physician at a local medical facility in the event of an emergency.

Signature of Parent/Guardian _____ Date _____ /_____ /_____

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STOP THIS NEXT SECTION IS TO BE FILLED OUT BY A HEALTHCARE PROVIDER ONLY. **STOP**

THIS FORM IS NOT ACCEPTABLE WITHOUT A HEALTHCARE PROVIDER'S SIGNATURE.

PART II - PHYSICAL EXAMINATION

Name: _____ **Date of birth**: _____ /_____ / _____ **Date of exam**: _____ /_____ / _____

Height: _____ inches **Weight**: _____ pounds **Pulse**: _____ bpm **BP**: _____ /_____ (_____ /_____ , _____ /_____)

Vision: R20 /_____ L 20 /_____ **Corrected**: Y N **Pupils**: □ equal □ unequal **Hearing**: R _____ L _____

MEDICAL	NORMAL	ABNORMAL FINDINGS	INTIALS
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Skin			
Neurological			
Genitalia/Pelvic *(optional)*			
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**	**INITIALS**
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Tuberculosis (TB) Risk Assessment

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

If YES, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

If NO, do you feel a tuberculin skin test is needed? ☐ Yes ☐ No

2. Tuberculin Skin Test (TST)

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

Result: _____mm of induration ****Interpretation**: ☐ negative ☐ positive

OVER →

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Tuberculosis (TB) Risk Assessment *(continued)*

3. Interferon Gamma Release Assay (IGRA)

Date obtained:_____/_____/_____ (M / D / Y) **Specify method**: ☐ QFT-G ☐ QFT-GIT ☐ Other

Result: ☐ negative ☐ positive ☐ intermediate

4. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: _____/_____/_____ (M / D / Y) **Result**: ☐ normal ☐ abnormal

CLEARANCE

☐ **Cleared**

☐ **Cleared after completing evaluation/rehabilitation for:** _____

_____

☐ **Not cleared for**: _____ **Reason**: _____

Recommendations: _____

_____

This is to certify that, in my opinion, _____ is in good health except as noted above, and is able to participate fully in academic work, physical education programs, and intercollegiate athletics.

Healthcare provider's signature: _____ **Date**: ____/____/_____

Healthcare provider's name (print/type): _____

Address: _____ **Phone**: _____

Wisconsin State Statute 36.25(46) requires that all students who will be residing in a campus residence hall receive yearly information regarding the risks associated with Hepatitis B and Meningococcal disease and the effectiveness of the vaccines available to prevent these diseases. The student who resides in campus housing must affirm whether he or she has received vaccinations against Hepatitis B and/or Meningococcal disease, and must provide the dates of the vaccinations, if any. The parents of minor students must provide this information. Please have these dates available when you check into housing.

Lawrence University requires that the Hepatitis B vaccine be initiated as a condition for enrollment. Immunization for Meningitis is strongly encouraged. Both vaccines are available on campus at the Landis Health Center, but it is recommended that students receive them prior to coming to campus.