Report of Health History

ANDERSON UNIVERSITY
Academic and Christian Discovery

This information is strictly for the use of Anderson University Health Services and will not be released without your knowledge or consent. All undergraduate students entering Anderson University are **required** to submit this Report of Health History to the Director of Health Services **by July 15**. The Report of Health History **requires** a physical examination completed by a licensed healthcare provider. It is recommended that a healthcare provider who is familiar with the student and his/her medical history provide the physical examination. Housing assignment may be withheld until completed Health History and immunization record has been submitted to Health Services.

The purpose of this Report of Health History is:

- to provide information in the event of a medical emergency
- to assist the licensed staff of Health Services by providing health information that may not be immediately obtainable from the student
- to assist students who are chronically ill or physically challenged in maximizing their experience at Anderson University.

TYPE OR PRINT IN INK ❑ Male ❑ Female **STUDENT CELL PHONE** _____

STUDENT'S LAST NAME FIRST NAME | MIDDLE NAME | MAIDEN NAME | DATE OF BIRTH

STREET ADDRESS | CITY | STATE | ZIP | COUNTRY

HOME PHONE | BUSINESS PHONE

FATHER'S NAME | ADDRESS | TELEPHONE

MOTHER'S NAME | ADDRESS | TELEPHONE

SPOUSE'S NAME | ADDRESS | TELEPHONE

Personal History *(to be completed by student)*

Do you currently have trouble with . . . *(Please check yes or no for each.)*

	Yes	No		Yes	No		Yes	No		Yes	No
Eyes	❑	❑	Throat	❑	❑	Stomach	❑	❑	Back	❑	❑
Ears	❑	❑	Teeth	❑	❑	Intestines	❑	❑	Muscles/Joints	❑	❑
Nose	❑	❑	Heart	❑	❑	Kidneys	❑	❑	Nerves	❑	❑
Mouth	❑	❑	Lungs	❑	❑	Bladder	❑	❑	_____	❑	❑

Have you . . . *(Please check yes or no for each. If yes, please explain.)*

	Yes	No	Explanation		Yes	No	Explanation
Had surgery	❑	❑	_____	**FEMALES ONLY:**			
Broken a bone	❑	❑	_____	Had menstrual problems	❑	❑	_____
Attempted suicide	❑	❑	_____	Had breast problems	❑	❑	_____
Had a seizure	❑	❑	_____	Been pregnant	❑	❑	_____

Had physical activity restricted during the past five years *(Give reason and duration.)* Yes ❑ No ❑ _____

Had any illness or injury or been hospitalized other than already noted Yes ❑ No ❑ _____

Have you been diagnosed with or treated for . . . *(Please check yes or no for each.)*

	Yes	No		Yes	No		Yes	No
Headaches/migraines	❑	❑	Anxiety/depression	❑	❑	Diabetes	❑	❑
Fainting	❑	❑	Insomnia	❑	❑	Hepatitis	❑	❑
High or low blood pressure	❑	❑	Asthma	❑	❑	Tuberculosis	❑	❑

List all medications you are currently taking.

Medication	Frequency	Dose	Medication	Frequency	Dose

List any allergies you have. *(environmental, food, medication, other)*

_____

_____

Family History *(to be completed by student)*

	Name	Age	State of Health	Occupation	Age at Death	Cause of Death
Father						
Mother						
Siblings						
Children						

Do you have any relatives who have . . . *(Please Check yes or no for each. If yes, list relationship to you.)*

	Yes	No	Relationship		Yes	No	Relationship
Tuberculosis	❑	❑		Stroke	❑	❑	
Diabetes	❑	❑		Epilepsy/seizures	❑	❑	
Kidney disease	❑	❑		Mental illness	❑	❑	
Heart disease	❑	❑		Committed suicide	❑	❑	
Arthritis	❑	❑		High blood pressure	❑	❑	
Stomach disorders	❑	❑		Breast cancer	❑	❑	

Consent for Treatment *(to be signed and dated by student and parent or legal guardian)*

I have reviewed the above information and believe it to be accurate. I request and authorize the physicians and staff of Anderson University Health Services, or the duly authorized designee(s) of such physicians and staff, and any other licensed healthcare provider to provide and perform such medical and surgical care, tests, procedures, drugs, and other services and supplies as are considered necessary and advisable by such provider for the health and well-being of

_____ ***(student's name)***, including, but not limited to, anesthesia, pathology, radiology, and other services and tests for communicable diseases, ordered by such health care provider.

I hereby consent to the use of foregoing consent form or any part thereof and to its release to such other person or institution as the physicians and staff of Anderson University Health Services may deem necessary or desirable at any time.

I have read and understand the Notice of Privacy Practices.

I have reviewed and understand the accompanying Overview of Meningococcal Information. I understand that the Meningococcal Meningitis vaccine offers protections against certain strains of *Neiserria Meningitis*, and that the vaccine is available through family physician offices or clinics.

_____ _____

STUDENT'S SIGNATURE DATE PARENT/LEGAL GUARDIAN'S SIGNATURE DATE

*Parent/legal guardian **must sign** if student is not age 18 by the beginning of Semester 1.*

Adequate health insurance is recommended. *Please contact Human Resources, Decker Hall Room 10, or 765.641.4132, for more information.*

STUDENT'S LAST NAME | FIRST NAME | MIDDLE NAME | ID NUMBER

Report of Physical Examination *(to be completed by physician)*

INSTRUCTIONS FOR PHYSICIAN:

1. Please review the student's Report of Health History and comment on all positive answers.
2. Complete a physical examination using this form.
3. **Sign this form before returning to student.**

Information provided on this form will not be release without the student's consent, and will only be used for providing health care.
Physical examination and tuberculosis test must have occurred within the last twelve (12) months.

AGE (YRS.) | HEIGHT (IN.) | WEIGHT (LBS.) | TEMPERATURE

PULSE RATE | RESPIRATION | BLOOD PRESSURE

Special needs or considerations *(Submit official documentation for approval.)*

Required tuberculosis skin test (mantoux). Must be current within 1 year.

Date of test _____ Site _____

Date read _____ Results _____ mm.

If TB test results exceed 10 mm. of induration, a chest X-ray is REQUIRED.

Date of X-ray _____ Results _____

Are there any abnormalities of the following systems? *(Please check yes or no for each. If yes, please explain.)*

	Yes	No	Explanation		Yes	No	Explanation
Head	❑	❑		Cardiovascular/	❑	❑	
Eyes (nonacuity)	❑	❑		Hematological			
Ears	❑	❑		Genirourinary	❑	❑	
Nose	❑	❑		Hernia	❑	❑	
Throat	❑	❑		Musculoskeletal	❑	❑	
Teeth	❑	❑		Metabolic/endocrine	❑	❑	
Respiratory	❑	❑		Neuropsychiatric	❑	❑	
Gastrointestinal	❑	❑		Skin	❑	❑	

Is there loss or serious impaired function of any paired organ?	Yes ❑	No ❑	
Is the student now under treatment for a serious medical condition?	Yes ❑	No ❑	
Is the student now under treatment for serious emotional condition?	Yes ❑	No ❑	
Do you have any recommendations regarding the care of this student?	Yes ❑	No ❑	
Any limitations for physical activity? *(recreation, sports, intramurals, etc.)*	Yes ❑	No ❑	

Additional comments *(details not otherwise documented on this form)*

PHYSICIAN'S NAME | SIGNATURE | DATE

STREET ADDRESS | CITY | STATE | ZIP | COUNTRY

TELEPHONE | FAX

Report of Required Immunization

STUDENT: This form should be returned to Anderson University by Aug. 1 to complete your admissions process.

This requirement must be met in one of two ways. **Indicate your preference by checking one of the two boxes below:**

❑ Have a physician complete this form and return it to you. Then you may return it by mail or deliver to Student Health Services.

❑ You may submit a written request for medical or religious exemption. *(If this box is checked, an exemption form will be sent to you by mail.*

Student's Statement *(to be completed by the student and signed by student and parent/legal guardian)*

STUDENT'S LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____ MAIDEN NAME _____

SSN _____ DATE OF BIRTH _____

All immunizations meet the requirements established by the Indiana State Department of Health and Department of Education. I authorize Anderson University Student Health Services to release this immunization report to the Indiana Department of Public Health or its designated representative, for compliance audits and in the event of a health or safety emergency.

STUDENT'S SIGNATURE _____ DATE _____

PARENT /LEGAL GUARDIAN'S SIGNATURE _____ DATE _____

Physician's Statement

(All live vaccines must have been given after 1969, on or after first birthday.)	MO / DAY / YR	MO / DAY / YR	MO / DAY / YR	MO / DAY / YR
A. **M.M.R. (Measles, Mumps, Rubella):** ***Two doses required.***				
1. Dose 1, given at age 12-15 mos. or later	#1 __/___/___			
2. Dose 2, given at age 4-6 yrs. or later, and at least one month after Dose 1	#2 __/___/___			
B. **Tetanus and Diphtheria:** *Primary series with DTaP or DTP and booster with Tetanus-Diphtheria (Td) or Tdap given within the last 10 years meets requirement.*				
1. Primary series of four doses with DTaP or DTP	#1 __/___/___	#2 __/___/___	#3 __/___/___	#4 __/___/___
2. Tetanus-Diphtheria (Td) or Tdap Booster given **within the last 10 years**	#2 __/___/___			
C. **Polio:** *Primary series in childhood meets requirement. Three primary series schedules are acceptable.*				
1. OPV alone (oral Sabin, three doses)	#1 __/___/___	#2 __/___/___	#3 __/___/___	
2. IPV alone (injected Salk, four doses)	#1 __/___/___	#2 __/___/___	#3 __/___/___	#4 __/___/___
3. IPV/Opv sequential	#1 __/___/___	#2 __/___/___	#3 __/___/___	#4 __/___/___
D. **Varicella:** *History of chicken pox, positive Varicella antibody, or* ***two doses*** *given at least one month apart after the age 13 yrs. meets requirement.*				
1. History of disease ❑ Yes ❑ No				
2. Varicella antibody ❑ Reactive ❑ Non-Reactive	IPV __/___/___	IPV	OPV	OPV
3. Immunization: a. Dose 1	#1 __/___/___			
b. Dose 2, given at least one month after first dose, if age 13 yrs. or older	#1 __/___/___			
E. **Hepatitis A** ***(Recommended): Two doses*** *or positive surface antibody meets requirement.*				
1. Immunization	#1 __/___/___	#2 __/___/___		
2. Hepatitis A surface antibody ❑ Reactive ❑ Non-Reactive	#1 __/___/___			
E. **Hepatitis B:** ***Three doses*** *or positive surface antibody meets requirement.*				
1. Immunization	#1 __/___/___	#2 __/___/___	#3 __/___/___	
2. Hepatitis B surface antibody ❑ Reactive ❑ Non-Reactive	__/___/___			
F. **Influenza:** *Annual immunization recommended*	__/___/___			
G. **Meningococcal:** *One dose, Quadrivalent polysaccharide vaccine* Immunization (required for students under age 25). Students with immunodeficiency should be vaccinated every 3-5 years. ***Must be current within 5 years.***	__/___/___			

PHYSICIAN'S NAME _____ SIGNATURE _____ DATE _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____ TELEPHONE _____

All records not in English must be accompanied by a certified translation. Please attach a copy of all laboratory results.

2016-17