Health Services • 604 E. College Avenue • North Manchester, Indiana • 46962

PLEASE TAKE THIS FORM TO YOUR PHYSICIAN to have the physical exam form on the facing page completed. THEN RETURN THE FORM TO: Health Services, Manchester University, 604 E. College Ave., North Manchester, IN 46962.

A PHYSICAL EXAMINATION IS REQUIRED FOR ADMISSION TO MANCHESTER UNIVERSITY. YOU ALSO ARE URGED TO HAVE ANY NECESSARY PREVENTIVE CARE (DENTAL CHECK-UP, EYE EXAM, ETC.) PRIOR TO ENROLLMENT.

IF YOU HAVE A HEALTH PROBLEM REQUIRING FOLLOW-UP OR CONTINUOUS CARE WHILE ATTENDING THE UNIVERSITY, WE WOULD APPRECIATE RECEIVING YOUR PHYSICIAN'S COMMENTS AND RECOMMENDATIONS BE INCLUDED WITH THE PHYSICAL FORM OR UNDER SEPARATE LETTER.

HEALTH HISTORY

(To be filled in by the student. ***Due August 1.***)

(Please print)
Name ______________________________
Last name First name Middle name Student Social Security #

Address ______________________________
Street address or P.O. Box City State ZIP Student Cell Phone

Date of birth ____________ Age ______ Place of birth ______________________ Sex: Male / Female
Month Day Year

Persons to notify in an emergency capable of giving permission for treatment in an emergency:

Name/relationship ______________ Home/cell phone (   ) ______________ Bus. phone (   ) ______________

Name/relationship ______________ Home/cell phone (   ) ______________ Bus. phone (   ) ______________

Personal physician ______________________________

Physician's address ______________________________ Telephone: ______________

Insurance Information (include copy of cards)

Name and address of health insurance company

______________________________ Phone (   ) ______________

______________________________ Group # ______________ Policy # ______________

______________________________ Social Security or I.D. # ______________

ALLERGIES

To medication ______________________________

Seasonal __________ Bee stings __________ Other __________ Food __________

Current medications, including dosage ______________________________

Have you ever had or do you now have any of the following?

	Yes	No		Yes	No		Yes	No
1. Severe acne			18. Headaches			36. Abortion		
2. Alcoholism or chemical dependency			19. Heart disease or heart murmur			37. Painful menstruation		
3. Anemia or other blood disease			20. Heat exhaustion / heat stroke			38. Lung disease		
4. Asthma			21. High blood pressure			39. Obesity		
5. Bone or joint disease			22. Hepatitis			40. Rheumatic fever		
6. Cancer			23. Kidney disease			41. Rupture of hernia		
7. **Chickenpox**			24. Major trauma, multiple injuries			42. Ruptured or enlarged spleen		
8. Any chronic disease			25. Personal link to Marfan Syndrome			43. Skin disease		
9. Concussion			26. Meningitis			44. Stomach trouble		
10. Diabetes or hypoglycemia			27. Mononucleosis			45. Intestinal trouble		
11. Drug or alcohol overdose			28. Psychiatric treatment			46. Thyroid disorder		
12. Ear disease			29. Psychological problems			47. Tonsillitis		
13. Eating disorder			30. Psychological counseling			48. Transfusion		
14. Epilepsy or seizures			31. Suicide attempts			49. Tuberculosis		
15. Eye disease			32. Pneumonia			50. Unconsciousness		
16. Genital herpes			33. Premenstrual syndrome			51. Other serious illness		
17. Recurrent sexually transmitted disease			34. Pregnancy			52. Other medical problems		
			35. Surgeries			53. Hospitalization		

Please explain all YES answers. ______________________________

____

Do you have two functioning: eyes? yes ❑ no ❑ kidneys? yes ❑ no ❑ testicles / ovaries? yes ❑ no ❑

FAMILY HISTORY

Among your **blood** relatives is there any history of the following:

	Yes	No	Relationship
1. Hypertension			
2. Heart attack			
3. Diabetes			
4. Cancer			
5. Kidney disease			
6. Suicide or depression			
7. Alcoholism or chemical dependency			
8. Tuberculosis			
9. Eating disorders			

Please list any other significant family history. ____________________

HEALTH HABITS

	Yes	No	
1. Do you regularly get six to eight hours of sleep?			
2. Do you regularly eat three meals a day?			
3. Are you satisfied with your weight/appearance?			
4. Do you smoke cigarettes, a pipe, or cigars, or use “smokeless tobacco”?			If yes, how often?
5. Do you drink alcoholic beverages?			If yes, how often?
6. Do you use “street drugs”?			If yes, how often?
7. If sexually active, do you take precautions to prevent pregnancy and sexually transmitted diseases?			
8. Have you had regular health check-ups?			

During the past two weeks have you been bothered by:

Little interest or pleasure in doing things? ❑ Yes ❑ No

Feeling down, depressed or hopeless? ❑ Yes ❑ No

❑ Please check if you will be participating in an NCAA affiliated sport program (not including intramurals) while at Manchester University.

Manchester University Health Services staff is committed to the privacy of student medical records in accordance with Indiana State Law.

I hereby consent and give my permission to health care providers employed by Manchester University to release medical information that may be required to (1) other health care professionals in order to provide appropriate, timely, quality health care for me, and (2) Counseling Services, Residence Life, Campus Safety, Athletics and/or other health providers to which I may be referred for further evaluation and treatment. I also give permission to the University to contact my parent(s) or guardian(s) in order to provide them with information regarding my medical condition when necessary.

Student’s signature ____________________

PHYSICAL EXAMINATION

(To be completed and signed by MD, NP, or PA)
Required by August 1.

Student name ______________________________ Date of Physical ______________

Height ________ Weight ________ Blood Pressure ____________ Pulse ________ Respiration ________

	Norm.	Abn.	N.E.	Comments
Head				
Eyes				
ENT				
Teeth				
Neck (incl. thyroid)				
Chest and lungs				
Heart				
Abdomen				
Genitalia (incl. hernia)				
Pelvic (if indicated)				
Rectal (if indicated)				
Spine				
Extremities and joints				
Neurologic				
Skin				
Emotional status				

Is the student free from communicable disease? Y or N

Drug Sensitivity? If so, what? ______________________________

Is the patient now under treatment for any medical or emotional condition? Y or N

If yes, what? ______________________________

Are you aware of any other pertinent information pertaining to this student's health that has not been addressed in the history and physical?

Y or N If yes, what? ______________________________

Is this student capable of participating in a full program of physical activity, including competitive athletics?

Y or N Limitations, if any? ______________________________

Impression(s) ______________________________

Recommendations ______________________________

MD, NP, or PA signature ______________________________ **Physician's phone** ______________

This completed form must be submitted as directed, regardless of anticipated participation in athletics.

IMMUNIZATIONS

A. TETNUS-DIPTHERIA ***Booster within last 10 years <u>REQUIRED</u>*** Date__/__/__ Date__/__/__

B. POLIO

1. Completed primary series of polio immunizations. Yes___ No___ Date of last booster __/__/__
2. Type of vaccine: Oral (OPV) ___ Injected (IPV) ___

C. MMR (Measles, Mumps, Rubella) ***Two injections <u>REQUIRED</u>*** Date__/__/__ Date__/__/__

D. MENINGOCOCCAL (Menactra) VACCINE ***<u>REQUIRED</u>*** Date__/__/__

E. TUBERCULOSIS ***(PPD <u>REQUIRED</u>, regardless of prior BCG inoculation. If living outside the U.S., testing must be done on campus at Health Services.)***

1. PPD (Mantoux) within past 12 months (tine or momovac not acceptable)
   Date given ___/___/___ Date Read ___/___/___ Results___ mm induration

2. Chest X-Ray (REQUIRED if positive Mantoux)
   Date done ___/___/___ X-Ray results

F. VARICELLA (Chicken Pox) ***Advised if no history of disease.***

1. History of Disease Yes___ No___ Vaccinated Date__/__/__ Date__/__/__

G. HEPATITIS B ***Advised, but not required***

Three injection series #1 Date__/__/__ #2 Date__/__/__ #3 Date__/__/__

H. HUMAN PAPILLOMAVIRUS (females only) ***Advised, but not required***

Three injection series #1 Date__/__/__ #2 Date__/__/__ #3 Date__/__/__

I. OTHER VACCINES (please list with dates)

_________________________ Date__/__/__ _________________________ Date__/__/__

TO THE BEST OF MY KNOWLEDGE THE ABOVE IMMUNIZATIONS WERE GIVEN.

ADDRESS STAMP

____

MD, NP, or PA signature

( )_______________________________________

Phone

Date _______________________________________

I authorize Manchester University Department of Health Services to administer medical and surgical services and immunizations and to perform emergency procedures, as necessary, or refer to duly-licensed medical personnel when indicated (including outside hospitals).

I hereby state that I am capable of safely participating in vigorous physical activity offered through physical education and intramural and intercollegiate athletics, unless otherwise noted in this health inventory.

_______ Yes _______ No

The information reflected in this form is complete and accurate to the best of my knowledge.

_______________________________ _______________________________

Signature of student Signature of parent or guardian (if under 18 years of age)

Return to: Health Services
Manchester University
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