

# MEDICAL HISTORY & PHYSICAL REPORT

University Health Services

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Notre Dame, IN 46556

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**ALL STUDENTS ARE REQUIRED TO RETURN THIS COMPLETED FORM IN THE ENCLOSED ENVELOPE TO UNIVERSITY HEALTH SERVICES BY JULY 1<sup>ST</sup> if enrolling in Fall Semester or one month prior to enrollment for other semesters. PRINT IN ENGLISH WITH INK.**

**FOR HEALTH SERVICE USE ONLY:** ND ID # \_\_\_\_\_

COMPLETE \_\_\_\_\_

INCOMPLETE DUE TO:

MMR #1 \_\_\_\_\_ #2 \_\_\_\_\_

Tetanus \_\_\_\_\_ TB \_\_\_\_\_

Signature: Tx of Minor \_\_\_\_\_

or Meningitis \_\_\_\_\_

Other \_\_\_\_\_

NOTIFICATIONS for deficiencies: \_\_\_\_\_

ENTERED \_\_\_\_\_

TO FILE \_\_\_\_\_

HOLD OFF \_\_\_\_\_

Reviewed by Physician \_\_\_\_\_

Class you are entering @ ND: (circle) Fr Soph Jr Sr Grad

If previously attended ND, list last year attended: \_\_\_\_\_

Name of Program/School \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Last) (First) (Middle) Mo. Day Yr

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Country \_\_\_\_\_ Country of Origin \_\_\_\_\_ Student Cell Phone: (\_\_\_\_) \_\_\_\_\_

Parent/Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_

## REQUIRED IMMUNIZATIONS

If not complete registration for classes will be delayed. Documentation may be obtained from your health care provider or previous school records. If documentation is unavailable, re-immunization or blood test (titer) to determine level of immunity is required.

### ALL STUDENTS:

**MMR (Measles, Mumps, Rubella)** Two doses required if born after 1956. Titer results may be attached in lieu of immunization records.

1. Dose 1 given at age 12-15 months or later # 1 \_\_\_\_\_  
Month / Day / Year

2. Dose 2 given at least one month after first # 2 \_\_\_\_\_  
Month / Day / Year

**Tetanus-Diphtheria** - Must be within the last 10 years \_\_\_\_\_ OR **Tetanus-Diphtheria-Pertussis** \_\_\_\_\_  
Month / Day / Year Month / Day / Year

### FRESHMEN STUDENTS ONLY:

**Meningococcal** One dose - preferably at entry into college for freshmen living in residence halls who wish to reduce their risk of Meningococcal disease. Any undergraduate who wishes to reduce his/her risk of disease may consider the vaccine.

Received vaccine \_\_\_\_\_ OR Student signature (or parent if <18yrs of age) is required if vaccine declined  
Month / Day / Year Signature Date \_\_\_\_\_  
Month / Day / Year

### INTERNATIONAL STUDENTS ONLY:

Tuberculosis Test (MUST BE PERFORMED IN THE UNITED STATES.) OR Available at Notre Dame Health Center upon arrival to campus.

Date Given \_\_\_\_\_ Date Read \_\_\_\_\_ Result \_\_\_\_\_ BCG Vaccine? Yes \_\_\_ No \_\_\_ Date \_\_\_\_\_  
Month Day Year Month Day Year (Record as mm of induration) Month Day Year

Chest X-ray \_\_\_\_\_ Result of X-Ray \_\_\_\_\_ Medications Received \_\_\_\_\_ From \_\_\_\_\_ thru \_\_\_\_\_  
(Attach copy of X-Ray report done in the U.S.) Month / Year Month / Year

### RECOMMENDED IMMUNIZATIONS

**Hepatitis A** - Series of two

Dose #1 \_\_\_\_\_ Dose #2 \_\_\_\_\_  
Mo. Day Yr. Mo. Day Yr.

**Hepatitis B** - Series of three

Dose #1 \_\_\_\_\_ Dose #2 \_\_\_\_\_ Dose #3 \_\_\_\_\_  
Mo. Day Yr. Mo. Day Yr. Mo. Day Yr.

**Polio** - Date of last booster: \_\_\_\_\_

**Combined Hepatitis A and Hepatitis B** - Series of three

Dose #1 \_\_\_\_\_ Dose #2 \_\_\_\_\_ Dose #3 \_\_\_\_\_  
Mo. Day Yr. Mo. Day Yr. Mo. Day Yr.

**Varicella** (Chicken Pox)

Dose #1 \_\_\_\_\_ Dose #2 \_\_\_\_\_  
Mo. Day Yr. Mo. Day Yr.

**Gardasil** (HPV) - Series of three

Dose #1 \_\_\_\_\_ Dose #2 \_\_\_\_\_ Dose #3 \_\_\_\_\_  
Mo. Day Yr. Mo. Day Yr. Mo. Day Yr.

or History of Disease? Yes \_\_\_ No \_\_\_ Date \_\_\_\_\_  
Mo. Yr.

Other Immunizations \_\_\_\_\_

**REQUIRED AUTHORIZATION FOR CARE IF STUDENT IS UNDER AGE 18:** I concur with the above and authorize, at the discretion of the Health Center personnel, medical and surgical care including but not limited to: examinations, treatments, and immunizations for my son or daughter. In the event of serious disease or injury or the need for major surgery, I understand that all reasonable efforts will be made to contact me, but that failure to make contact will not prevent emergency treatment necessary to help preserve life or health.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# COMMUNICABLE DISEASE INFORMATION SHEET

Notre Dame Health Services provides this information in accordance with Indiana State Law. These vaccines are recommended by the Centers for Disease Control and Prevention (CDC), the American College Health Association (ACHA), American Medical Association (AMA).

## MUMPS

*What is Mumps?*

It is an acute viral infection with flu-like symptoms. Many complications can arise especially in adult and adolescent patients. The US is experiencing an increase of Mumps. Check with your Health Care provider and verify you have received **two** Mumps vaccines. A blood titer can be drawn to check immunity.

*How is it transmitted?*

It is spread by direct contact with respiratory droplet and saliva.

*Why are college students at risk?*

It can be spread quickly through a communal living environment such as a dorm.

*How can one reduce the risk?*

Two Mumps Vaccines are recommended and are available at the Health Center.

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## HEPATITIS B

*What is Hepatitis B?*

It is an infection of the liver caused by the Hepatitis B Virus. It may manifest with flu-like symptoms, jaundice, or no symptoms at all. The Hepatitis B virus can be 100 times more contagious than the AIDS Virus. One in 20 people has or will someday contract Hepatitis B.

*How is it transmitted?*

It is transmitted directly or indirectly through infected body fluids.

*Why are college students at risk?*

75% of cases occur between the ages of 15 and 39 years. Activities such as sports, communal living, social behavior, etc. put college students at greater risk.

*How can one reduce the risk?*

The Hepatitis B Vaccine is safe and effective. It is a series of three injections over a six month period. The vaccine is available at the Health Center.

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## PERTUSSIS

*What is Pertussis?*

It is a highly communicable disease that lasts for many weeks and is typically manifested with severe coughing, "whooping" and vomiting. A steady rise has been noted in the US.

*How is it transmitted?*

It is spread through direct contact with respiratory droplets from an infected person.

*Why are college students at risk?*

Again, communal living and exposure to large populations from all areas of the world.

*How can one reduce the risk?*

It is recommended that students receive a Tdap (Tetanus, Diphtheria and adult Pertussis) vaccine as an adolescent or adult 5 years after their last Td (Tetanus, Diphtheria) booster. The vaccine is available at the Health Center.

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## MENINGITIS

*What is Meningitis?*

It is an inflammation of the brain and spinal cord caused either by a virus or Bacteria: Viral- most common, runs a short uneventful course.

Bacterial – rare but serious and potentially life-threatening. Requires early detection and treatment. 300 Americans die annually.

*How is it transmitted?*

It is spread though droplets of respiratory secretions from the infected person.

*Why are college students at risk?*

Living in a dorm setting, social behaviors such as sharing eating utensils, etc.

*How can one reduce the risk?*

Wash hands frequently, don't share eating utensils, and consider a Menactra Vaccine that has been effective against four strains of the disease. The vaccine will be available at the Health Center. More information at <http://uhs.nd.edu>.

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Student signature (or parent if <18yrs of age) is **required**, acknowledging receiving the above information regarding the risk of meningitis and other communicable diseases.

Signature \_\_\_\_\_

Date \_\_\_\_\_  
Month / Day / Year

**HEALTH QUESTIONNAIRE** *(To be completed by student prior to Physical Evaluation by Health Care Provider on reverse side)*

Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

<i>Explain all "Yes" answers:</i>	YES	NO
1. Has a doctor ever denied or restricted your participation in a sport for any reason? If YES, explain:		
2. Do you have any ongoing or chronic medical conditions (like diabetes or asthma)? If YES, explain:		
3. Are you currently taking any medications (prescriptions, over-the-counter, herbs, vitamins or Supplements)? If YES, list:		
4. Do you have allergies to any medications, foods, pollens or stinging insects? If YES, list:		
5. Have you ever passed out or nearly passed out DURING exercise? If YES, explain:		
6. Have you ever passed out or nearly passed out AFTER exercise? If YES, explain:		
7. Have you ever had discomfort, pain, or pressure in your chest during exercise? If YES, explain:		
8. Does your heart race or skip beats during exercise? If YES, explain:		
9. Has a doctor ever told you that you have (check all that apply): High blood pressure ____ A heart murmur ____ High Cholesterol ____ A heart infection ____		
10. Has a doctor ever ordered a test for your heart (ECG, echocardiogram)? If YES, explain:		
11. Has anyone in your family died before the age of 50 for no apparent reason? If YES, explain:		
12. Does anyone in your family have Marfan's syndrome? If YES, explain:		
13. Have you ever had surgery? If YES, explain:		
14. Have you ever had a stress fracture? If YES, explain:		
15. Have you been told that you have, or had, a cervical spine (neck) problem? If YES, explain:		
16. Do you have asthma or any other lung condition? If YES, explain:		
17. Were you born without, or are you missing a kidney, an eye, a testicle, or any other organ? If YES, explain:		
18. Have you had infectious mononucleosis (mono) in the last 6 months? If YES, explain:		
19. Have you ever had a head injury or concussion, or been confused and lost your memory after being hit in the head? If YES, explain:		
20. Have you ever had a seizure? If YES, explain:		
21. Have you ever been unable to move your arms or legs after being hit or falling? If YES, explain:		
22. When exercising in the heat, do you have severe muscle cramps or become ill? If YES, explain:		
23. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? If YES, explain:		

**FEMALES ONLY:**

24. Have you ever had a menstrual period?     YES     NO  
 25. How old were you when you had your first menstrual period? \_\_\_\_\_  
 26. How many periods have you had in the last year? \_\_\_\_\_

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Student Name \_\_\_\_\_ Date \_\_\_\_\_  
*Signature* *Print Name*

Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

## Physical Evaluation of Student

**(To be completed by a health care provider for clearance of the student to participate in the University's physical education program and any travel abroad program, volunteer service program, club sport, intramural sport, and/or participate as a walk-on candidate for a varsity sport. ROTC students may submit their DODMERB physical in lieu of this exam.)**

### MEDICAL HISTORY *(Please also review patient questionnaire on the back of this form)*

\_\_\_\_\_ No Significant Medical History Allergies to Medications : \_\_\_ No \_\_\_ Yes, List: \_\_\_\_\_

Other Significant Allergies (foods, bee stings, etc): \_\_\_ No \_\_\_ Yes, List \_\_\_\_\_

Receive Allergy Injections? \_\_\_ No \_\_\_ Yes

\_\_\_\_\_ Routine Prescription Drugs: \_\_\_\_\_

Please Provide Details or attach documentation of any significant Medical History:

\_\_\_\_\_  
 \_\_\_\_\_

Significant Family Hx : \_\_\_\_\_

\_\_\_\_\_

### PHYSICAL EXAM

Blood Pressure \_\_\_\_/\_\_\_\_ Pulse \_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

	Nml	Abnml	Comments		Nml	Abnml	Comments
Appearance				Neck			
Eyes/Ears/Nose/Throat				Back			
Lymph Nodes				Shoulder/arm			
Heart				Elbow/forearm			
Pulses				Wrist/hand			
Lungs				Hip/thigh			
Abdomen				Knee			
Genitalia				Leg/ankle			
Skin				Foot			

### CLEARANCE

- Cleared for participation. Based on my review of the patient questionnaire and my physical exam, this student is presently physically qualified to participate in the University's physical education program, and any travel abroad program, volunteer service program, intramural or club sport, and/or participation in a varsity sport.

Not cleared for participation in : \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Name of Health Care Provider: \_\_\_\_\_

Print/type

Signature

Office Address: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date of Physical Exam

*(Completed within one year of arrival on campus for all Students OR within six months if student athlete.)*