UNIVERSITY OF NOTRE DAME
University Health Services

REQUIRED

University of Notre Dame Immunization Form

Enter info and upload records on Online Student Health (nd.medicatconnect.com)

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: ___/___/___ ND ID: _____ If previously attended ND, list year: _____

Emergency Contact Name: _____ Emergency Contact Phone Number: _____

REQUIRED IMMUNIZATIONS

MMR		Date #1		Date #2
OR	**Measles (Rubeola)**	Date #1	Date #2	OR Laboratory Evidence of Immunity Include Report
	Mumps	Date #1	Date #2	OR Laboratory Evidence of Immunity Include Report
	Rubella (German Measles)	Date		OR Laboratory Evidence of Immunity Include Report
Tetanus-Diphtheria-Pertussis		Tdap Date		Td, (if Tdap is >10 years) Date
Meningococcal Vaccine – Quadrivalent – All incoming students under age 21 and living on campus; 1 dose after age 16				Date / Name of Vaccine
Hepatitis B		Date #1	Date #2 / Date #3	OR Laboratory Evidence of Immunity Include Report
Varicella (Chicken Pox)		Date #1 / Date #2	**OR** birth in U.S. before 1980, **OR** Health Provider documentation of disease Date of Disease ___/___ (mo/yr)	OR Laboratory Evidence of Immunity Include Report

ADDITIONAL IMMUNIZATION HISTORY

Hepatitis A	Date #1		Date #2	
HPV	Date #1	Date #2	Date #3	Name of Vaccine
Meningitis B	Date #1	Date #2	Date #3 (if applicable)	Name of Vaccine
Pneumococcal Vaccine	Date	Name of Vaccine		
Japanese Encephalitis	Date #1	Date #2	Booster Date	
Rabies	Date #1	Date #2	Date #3	
Typhoid	__ Injectable __ Oral	Date		
Yellow Fever	Date			
Polio Adult Booster	Date			

Signature of Health Provider: _____ Date: _____

Signing Provider is verifying all dates above are accurate

Health Provider Name: (Please Print):_____
Address:_____
Phone Number:_____

Clinic Stamp

AUTHORIZATION FOR CARE IF STUDENT IS UNDER AGE 18: I authorize, at the discretion of the UHS personnel, medical and surgical care including but not limited to: examinations, treatments, and immunizations for my child. In the event of serious disease or injury or the need for major surgery, 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: _____

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REQUIRED

HEALTH QUESTIONNAIRE

Name: _____ Date of Birth _____/_____/_____

Explain all "Yes" answers:	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? _____

Student Name _____ _____ Date _____
Signature *Print Name*

Form is OPTIONAL

Name: _____ Date of Birth _____/_____/_____
Month Day Year

MEDICAL HISTORY - *to be completed by student*

Allergy Injections ____No ____Yes

Significant Medical History: ____No ____ Yes, Define: _____

_____

Significant Family History_____

_____

PHYSICAL EVALUATION – *to be completed by Your Health Care Provider*

Physical Exam

Blood Pressure _____/_____ Pulse _____ Height_____ Weight _____

	Normal	Abnormal	Comments		Normal	Abnormal	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: _____
_____
_____

Signature of Health Provider: _____ Date of physical exam: _____

Health Provider Name: _____
Address:_____
Phone Number:_____

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