

MEDICAL HISTORY & PHYSICAL REPORT

University Health Services

100 Saint Liam Hall

Notre Dame, IN 46556

Phone# 574-631-7497 Fax# 574-631-6047

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: _____

ER Contact _____

ENTERED _____

TO FILE _____

HOLD OFF _____

HIGH RISK _____

Reviewed by Physician _____

ALL Students are **REQUIRED** to enter this information into our medical system via onlinestudenthealth.nd.edu and then mail the completed form to UNIVERSITY HEALTH SERVICES at least 1-2 months prior to the start of the semester. **The site opens 5/20 for Summer students and 6/20 for Fall students.**

Complete the form in English.

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. (Enter on line at onlinestudenthealth.nd.edu)

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 _____ / _____ / _____
Month / Day / Year **OR** Tetanus-Diphtheria-Pertussis _____ / _____ / _____
Month / Day / Year

FRESHMEN STUDENTS ONLY:

Meningococcal Two doses - scenario 1) 1st dose by the age of 11 or 12 with a Booster at age 16 #1 _____ / _____ / _____ #2 _____ / _____ / _____ **OR**
scenario 2) 1st dose between ages 13-15 with Booster between 16 -18 #1 _____ / _____ / _____ #2 _____ / _____ / _____ **OR**
scenario 3) 1st dose at age 16 with no Booster needed. #1 _____ / _____ / _____

OR Student can sign below acknowledging the risk of meningitis. Student signature (or parent if <18yrs of age) is **required** if vaccine declined

Signature _____ Date _____ / _____ / _____
Month / Day / Year

INTERNATIONAL STUDENTS ONLY: Tuberculosis Test (MUST BE PERFORMED IN THE UNITED STATES. Attach documentation of ALL testing)

OR Available at Notre Dame Health Center upon arrival to campus.

Mantoux SkinTest: Date Given _____ / _____ / _____ Date Read _____ / _____ / _____ Result _____ BCG Vaccine? Yes ___ No ___ Date _____ / _____ / _____
Month Day Year Month Day Year (Record as mm of induration) Month Day Year

OR Quantiferon-Gold (QFT-G): Date Done _____ / _____ / _____ Result _____
Month Day Year

IF POSITIVE RESULTS: Chest X-ray _____ / _____ / _____ Result of X-Ray _____ Medications Received _____ From _____ / _____ / _____ thru _____ / _____ / _____
Month Day Year 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.

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.

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.

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.

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 through 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>.

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 ____/____/____

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 _____
Signature

_____ Date _____
Print Name

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

MEDICAL HISTORY - to be completed by student

Allergies to Medications: ____ No ____ Yes, List: _____

Other Significant Allergies (foods, bee stings, etc): ____ No ____ Yes, List _____

Allergy Injections ____ No ____ Yes

Routine Prescription Drugs: _____

Significant Medical History: ____ No ____ Yes, Define: _____

Significant Family History _____

PHYSICAL EVALUATION – to be completed by Health Care Provider

To be completed by a health care provider within 1 year of enrollment.
 Form must be completed within 6 months of enrollment for student athlete or walk-on candidate for a varsity sport.
 ROTC students may submit their DODMERB physical in lieu of this exam.

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: _____

Name of Health Care Provider: _____

Office Address: _____

Signature _____

 Date of Physical Exam