To the Student:
You have been accepted. Information you provide will not be used to influence your situation at the College; it will be used, if necessary, solely as an aid to providing necessary health care while you are a student.

College of Saint Benedict
Health Services
37 South College Ave.
St. Joseph, MN 56374
Fax: 320-363-6396

Must be Completed and Returned by June 15th for Fall admission or February 1st for Spring admission.

CSB Health Form

CONFIDENTIAL (TO BE COMPLETED BY STUDENT BEFORE PHYSICAL EXAM)

Name (Print) _____ ___ ___
Last First Middle

Home Address: _____ City: _____ State: _____ Zip: _____

Student Cell Phone #: _____ Home phone #: _____ Birth Date: _____

Insurance Company: _____

Reminder: Please carry a copy of your health insurance identification card with you on campus.

FAMILY HISTORY

If any blood relative has a history of any of the following, please indicate and note age of death if applicable:

Illness	Relationship	Age of death	Illness	Relationship	Age of death
☐ High Blood Pressure			☐ Arthritis		
☐ Stroke			☐ Stomach Disease		
☐ Cancer			☐ Asthma		
☐ Diabetes			☐ Tuberculosis		
☐ Thyroid Disease			☐ Mental Illness		
☐ Anemia			☐ Epilepsy		
☐ Kidney Disease			☐ Other		

Please list number of brothers and sisters with their ages: _____

PAST MEDICAL HISTORY

Allergies: (Medications, foods, insects, latex, environmental)

MEDICATIONS TAKEN REGULARLY: (Include: prescription and nonprescription drugs)

SURGERIES/ACCIDENTS/HOSPITALIZATIONS:

MEDICAL HISTORY

Check if you have had any of the following symptoms or diseases. Comment below.

- ☐ Scarlet or Rheumatic Fever
- ☐ Measles
- ☐ German Measles (Rubella)
- ☐ Mumps
- ☐ Malaria
- ☐ Mononucleosis
- ☐ Sinusitis
- ☐ Vision problems
- ☐ Ear, Nose, Throat trouble
- ☐ Pneumonia
- ☐ Asthma
- ☐ Chronic cough
- ☐ Acne
- ☐ Other skin problems
- ☐ Headaches
- ☐ Sleep problems
- ☐ Anxiety
- ☐ Phobias
- ☐ Depression
- ☐ Worry or Nervousness
- ☐ Suicidal thoughts
- ☐ Other Mental Health Concerns
- ☐ Head injury
- ☐ Convulsions
- ☐ Pain/pressure in chest
- ☐ Palpitations (Heart)
- ☐ High or Low Blood Pressure
- ☐ Heart Murmur
- ☐ Chronic fatigue
- ☐ Thyroid disease
- ☐ Disease or injury of joints
- ☐ Back problems
- ☐ Tumor/Cyst
- ☐ Cancer
- ☐ Jaundice/Liver trouble
- ☐ Stomach/Intestinal trouble
- ☐ Recurrent Diarrhea
- ☐ Anemia
- ☐ Recent weight gain/loss
- ☐ Dizziness/Fainting
- ☐ Eating Disorder
- ☐ Frequent urine infections
- ☐ Diabetes
- ☐ Tattoos
- ☐ Sexually Transmitted Diseases
- ☐ History of Alcohol/Drug Addiction

Social History
Cigarette use ☐ Yes ☐ No
Pk/Day _____
Alcohol use ☐ Yes ☐ No
Drinks/week _____
Street drug use ☐ Yes ☐ No

Menstrual History
- ☐ Irregular periods
- ☐ Severe cramps
- ☐ Excessive flow

NCAA SPORTS PARTICIPATION

NCAA rules state that all students participating in intercollegiate athletics must have a physical within *6 months* of the start of their varsity season's first practice.

Students planning on participating in NCAA varsity sports need to provide a copy of these completed forms to: CSB Athletic Training Room, 17A HCC, College of Saint Benedict, 37 S. College Ave., St. Joseph, MN 56374.

IMMUNIZATION RECORD

Required to be completed by health care provider or attach clinic immunization record. Return to Health Services before June 15th or February 1st.

Name: _____ Birth date: _____/_____/_____
Last First Middle Month Day Year

REQUIRED IMMUNIZATIONS

Minnesota law requires proof of immunization against Measles, Mumps, Rubella, Tetanus and Diphtheria.

MMR (Measles, Mumps, Rubella) Dose #1 given at age 12 months or later. Dose #2 given at least 28 days after first dose.
Two doses required prior to entrance. #1 _____/_____/_____ #2 _____/_____/_____
Month Day Year Month Day Year

Tetanus/Diphtheria
Primary series of 4 doses DPT #1 _____/_____/_____ #2 _____/_____/_____ #3 _____/_____/_____ #4 _____/_____/_____
Mo. Day Year Mo. Day Year Mo. Day Year Mo. Day Year

TD/Tdap (Tetanus-Diphtheria Booster) One dose required with the **last 10 years.** #1. _____/_____/_____ ☐ Td or ☐ Tdap?
Month Day Year

OTHER IMMUNIZATIONS

Polio 1. _____/_____/_____ 2. _____/_____/_____ 3. _____/_____/_____ 4. _____/_____/_____
Month Day Year Month Day Year Month Day Year Month Day Year

Meningitis 1. _____/_____/_____ ☐ Menomune or ☐ Menactra?
Month Day Year

Hepatitis A 1. _____/_____/_____ 2. _____/_____/_____
Month Day Year Month Day Year

Hepatitis B 1. _____/_____/_____ 2. _____/_____/_____ 3. _____/_____/_____
Month Day Year Month Day Year Month Day Year

HPV 1. _____/_____/_____ 2. _____/_____/_____ 3. _____/_____/_____
Month Day Year Month Day Year Month Day Year

Varicella Have you had chicken pox? ☐ Yes ☐ No

If no, please indicate date of vaccinations.
1. _____/_____/_____ 2. _____/_____/_____
Month Day Year Month Day Year

History of reaction to immunizations: ☐ Yes ☐ No Which immunizations?_____ Type of Reaction: _____

Signature of Medical Professional_____ Date _____

CONSCIENTIOUS / RELIGIOUS EXEMPTION

Must fill out if unable to meet required immunizations due to conscientious or religious belief.

MUST BE NOTARIZED

I hereby certify by notarization that my conscientious or religious belief is opposed to immunizations.

_____ _____
Student Signature (or parent or legal guardian if under 18 years of age) Date

Subscribed and sworn to me on the _____ day of _____, 20_____.

_____
Signature of Notary

MEDICAL EXEMPTION

MUST BE COMPLETED IF UNABLE TO MEET REQUIRED IMMUNIZATIONS DUE TO MEDICAL CONTRAINDICATIONS.
The physical condition of the above named person is such that immunization would endanger life or health, or is medically contraindicated due to other medical conditions.

_____ _____
Signature of Medical Professional *Date*

HEALTH CARE PROVIDER EXAMINATION
PAGE 3 TO BE COMPLETED BY THE EXAMINING HEALTH CARE PROVIDER

Please review the student's history on the previous two pages and complete the following section. Please comment on all positive answers.
THIS STUDENT HAS BEEN ACCEPTED AND THIS INFORMATION WILL NOT AFFECT HIS/HER STATUS. This information is confidential and will not be released without written student consent.

Student's Last Name First Name Middle

	Normal	Abnormal
1. Eyes		
2. Head, Ears, Nose or Throat		
3. Respiratory		
4. Cardiovascular		
5. Gastrointestinal/Abdomen		
6. Hernia/Genitalia		
7. Genitourinary		
8. Musculoskeletal		
9. Metabolic/Endocrine		
10. Mental/Emotional Status		
11. Skin		

12. BP: _____/_____ **13.** PULSE: _____

14. HEIGHT: _____ **15.** WEIGHT: _____

16. Does the student have a disability or other medical condition? If yes, please explain, including the treatment plan.
□ Yes □ No
EXPLAIN:

*ATHLETIC PARTICIPATION

REQUIRED FOR STUDENTS WHO ARE PARTICIPATING IN ANY NCAA INTER-COLLEGIATE VARSITY SPORT

In order for the student to participate in any NCAA inter-collegiate varsity sports, the physical examination and lab work must be completed and participation box checked.

HEMOGLOBIN: _____ or
HEMATOCRIT: _____

Sickle cell trait testing:
□ Negative □ Positive
□ Student chose to waiver test
Sickle cell trait testing or a signed waiver is required. A waiver form is available from the CSB Athletic Trainer.

COMMENT ON ANY ABNORMALITIES OR RESTRICTIONS:

***May participate:** □ **Yes** □ **No**

TUBERCULOSIS SCREENING

1. Does the student have signs or symptoms of active tuberculosis disease?
☐ Yes ☐ No
If No, proceed to 2. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

2. Is the student a member of a high-risk group or is the student entering the US from a foreign country?
☐ Yes ☐ No
If No, stop.
If Yes, perform either IRGA or tuberculin skin test (TST).
IGRA results:
☐ Negative ☐ Positive

Tuberculin Skin test:
Date Given: _____/_____/_____ Date Read: _____/_____/_____
Month Day Year Month Day Year
Result:_____ (Record actual mm of induraton; if no induration, write "0").
Interpretation (based on mm of induration as well as risk factors):
☐ Positive ☐ Negative

3. Chest x-ray (required if TST or IGRA is positive) result:
☐ Normal ☐ Abnormal
Date of chest x-ray: _____/_____/_____
Month Day Year

4. Patient is considered free of active tuberculosis: □ Yes □ No

HEALTH CARE PROVIDER SIGNATURE (required)

*Health Care Provider Signature: _____
Office Phone: _____ Office Fax: _____
Print Name: _____ Date: _____
Clinic Address: _____