

Report of MEDICAL HISTORY

Required of all students – Return completed form by July 15 to:

Saint John's Health Center, Box 7177, Collegeville, MN, 56321-7177

Phone: (320) 363-3142 • Fax: (320) 363-3124

Web site: www.csbsju.edu/sjuhealthcenter • E-mail: sjuhealthcenter@csbsju.edu

Please Print

Name _____ Today's date _____

_____ *Last* _____ *First* _____ *Middle* _____
Social Security Number _____ Date of birth (mm/dd/yy) ____/____/____ Age _____

Gender Female Male Citizenship U.S. Other _____

Home address _____

City _____ State _____ Zip _____ Telephone (____) _____-_____

NOTIFY IN CASE OF EMERGENCY

Name _____ Relation _____

Address _____ City _____ State _____ Zip _____

Telephone (____) _____-_____ Cell Phone (____) _____-_____

IMMUNIZATION FORM—Required prior to registration.

Minnesota Law (M.S. 135A.14) requires that all students born after 1956 and enrolled in a public or private post-secondary school in Minnesota be immunized against diphtheria, tetanus, measles, mumps, and rubella, allowing for specified exemptions indicated below. Data confirming the state-required immunizations and the immunization for polio and tuberculosis skin test are part of the admission process at Saint John's University.

If you were born before 1957, you are exempt from B & C. Complete items A & D. For immunization waiver, see below. Items E & F & G are recommended.

A. PROOF OF FREEDOM FROM TUBERCULOSIS—U.S. students encouraged to provide

Required for all international students. (dates of tests must be one month prior to attendance at SJU and verified by a physician)

Mantoux Skin Test Date given ____/____/____ Date read ____/____/____ Results _____ (record in millimeters)

or Chest X-ray Date taken ____/____/____ (copy of X-ray report must be attached)

B. MMR (Measles, Mumps, Rubella) 2 doses required

Dose 1 - immunized after 12 months Date ____/____/____

Dose 2 - immunized at 5 years or later Date ____/____/____

C. POLIO

Completed primary series Date ____/____/____

Last booster Date ____/____/____

D. TETANUS-DIPHTHERIA

Completed primary series Date ____/____/____

Received TD booster within last 10 years (required) Date ____/____/____

E. HEPATITIS B (Recommended)

Dose 1 Date ____/____/____

Dose 2 Date ____/____/____

Dose 3 Date ____/____/____

F. HISTORY OF CHICKEN POX (VARICELLA) Yes No

Vaccinated #1. Month _____ Year _____ #2. Month _____ Year _____

G. MENINGITIS (Recommended) Vaccinated month _____ Year _____

Please see Web site for information on hepatitis and meningitis

Signature of person completing form _____ Date _____

THIS FORM MUST BE COMPLETED AND RETURNED BY JULY 15.

Keep a copy of this form for your records.

By law, anyone over the age of 18 needs to give permission for release of medical information, EVEN TO PARENTS.

IMMUNIZATION WAIVER—Conscientious Exemption

I hereby certify by notarization that immunization against _____

is contrary to my conscientiously held beliefs. Student signature _____ Date _____

Subscribed and sworn before me on the _____ day of _____, 200 _____.

Notary signature _____

Self Assessment FORM

Name _____ Date of birth (mm/dd/yy) ____/____/____

Sport(s) _____

Positive answers should be discussed with your health care provider. Explain "Yes" answers below. Circle questions you don't know the answers to.

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an ongoing or chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes? Bleeding disorder? Hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	11. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below.		
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/calf
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper arm	<input type="checkbox"/> Foot	
before age 35?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>			
5. Do you have any current skin problems (for example, itching, rash, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	Explain "Yes" answers here _____		
6. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>	How many times a week do you spend at least 30 minutes doing vigorous physical exercise? _____		
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	List medications you take on a regular basis _____		
7. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
8. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
9. Do you use tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (e.g. to pollen, medicine, food, stinging insects, latex) _____		

REQUIRED SIGNATURE

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

Student signature _____ Date _____

Physical EXAMINATION

REQUIRED OF ALL STUDENTS

Today's date _____ Name _____
 Date of birth (mm-dd-yy) ____/____/____ Gender Female Male
 Height _____ Weight _____ BMI _____ Pulse _____ BP _____/_____
 Vision R 20/ _____ L 20/ _____ Corrected Yes No Hearing _____
 Allergies _____

LABS—if indicated

Urinalysis
 Protein _____
 Glucose _____
 Hemoglobin _____
 Total Cholesterol _____

	Normal	Comments
Eyes - Fundoscopic, Perra, EOM's		
Ears, Nose, Throat		
Mouth and Teeth/Dental		
Neck/Thyroid/Lymph Nodes		
Cardiovascular/Murmur, EKG if indicated		
Chest and Lungs		
Abdomen		
Skin		
Genitalia - Hernia		
Please assess ROM, strength in all listed joints		
Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/>		
Hands <input type="checkbox"/> Back <input type="checkbox"/> Hips <input type="checkbox"/> Quad/Hams <input type="checkbox"/>		
Knees <input type="checkbox"/> Feet <input type="checkbox"/> Ankle <input type="checkbox"/>		
CNS - reflexes, coordination		
Recommendations/explanations		

1. Is this applicant appropriately immunized and free from significant communicable disease? See page 1. Yes No
2. Does this applicant use tobacco? Yes No If yes, have you discussed the risk factors? Yes No
3. Has education about the use of alcohol, steroids and other drugs been offered to this applicant? Yes No
4. Have you discussed sexual issues with this applicant? Yes No
5. Is this applicant now under treatment for any medical or emotional condition? Yes No

REQUIRED ATHLETIC CLEARANCE—Required of all students

- Cleared for athletic participation.
 Cleared after completing evaluation/rehabilitation for _____

 Not cleared for _____ Reason _____
 Recommendation _____

PROVIDER INFORMATION—Required

Provider signature _____ Date _____
 Provider last name (please print) _____ Telephone (_____) _____ - _____
 Address _____
 City _____ State _____ Zip _____

REQUIRED SIGNATURE—All students must sign

I authorize Saint John's Health Center to inform the Athletic Department whether or not I am approved by my physician to participate in varsity, club and/or intramural sports activities. I understand that the Health Center will indicate either "Yes" or "No" and that no further information will be shared. This may be done with my consent. I also authorize Saint John's Health Center to share insurance information with the Saint John's Athletic Department.

Student signature _____ Date _____ Date of birth _____