

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 _____

HEALTH CARE PROVIDER REVIEW—To be signed by health care provider

Name _____ Signature _____
 Phone (____) _____-_____ Fax (____) _____-_____

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 _____

Remove Health Form from publication.

SJU HEALTH FORM

Return this form by July 15

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"/>	_____		
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
7. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	How many times a week do you spend at least 30 minutes doing vigorous physical exercise? _____		
8. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>	List medications you take on a regular basis _____		
9. Do you use tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>	_____		

			Allergies (e.g. to pollen, medicine, food, stinging insects, latex) _____		

REQUIRED SIGNATURES

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

Student signature _____ Date _____

Provider review 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, PERRLA, 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	
<input type="checkbox"/> Cleared for athletic participation.	
<input type="checkbox"/> Cleared after completing evaluation/rehabilitation for _____	
<input type="checkbox"/> Not cleared for _____ Reason _____	
<input type="checkbox"/> Recommendation _____	
M.D./N.P./P.A. signature _____	Date _____
Print last name _____ 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 _____

Parent/Student INSURANCE INFORMATION/WAIVER FORM

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

All students are required to have medical insurance.

Students are required to have a health insurance policy in force while attending Saint John's University. A student will be enrolled in and billed for the Student Injury and Sickness Insurance Plan (SAS) unless the student carries comparable insurance and submits the waiver by the deadline.

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

In case of emergency contact _____ at the following number:

Home phone (_____) _____-_____ Work phone (_____) _____-_____ Cell phone (_____) _____-_____

You must check one of the four boxes below

- I, as a student at Saint John's University, attest that I/my parents have insurance coverage under a current, in force insurance policy. This policy has a Major Medical Benefit of at least \$50,000, which is the minimum requirement.
- I, as a student-athlete at Saint John's University, attest that I/my parents have insurance coverage under a current, in force insurance policy. This policy has a Major Medical Benefit of at least \$75,000 and covers injuries that occur while participating in intercollegiate athletics, as required by the NCAA.
- I, as a student at Saint John's University, do not carry my own insurance, and wish to enroll in the SAS Basic Coverage Insurance plan offered by the college.
- I, as a student-athlete at Saint John's University, do not carry my own insurance and wish to enroll in the SAS insurance plan (Basic Coverage and Optional Sports Coverage) offered by the college. I understand there is a maximum benefit of \$75,000 on the Optional Sports Coverage, required by the NCAA. I also understand the deductible is \$500, and I accept responsibility for out of pocket expenses. **(SAS enrollees must fill out and turn in an application to the Saint John's Health Center.)**

If you have checked Box 1 or Box 2 fill in the information below.

Insurance Company Name _____

Insurance Company Address _____

Policy Holder Name _____

ID # _____ Group # _____

Effective Date of Policy ____/____/____ Expiration Date ____/____/____

Policy Limit _____ Policy Deductible _____ Co-Pay _____

I certify that the above information is true. I understand and agree that I will maintain health insurance that meets the minimum requirements while I am enrolled as a student at Saint John's University. I understand I must complete a waiver form for each academic year. If there is a change in coverage or expiration of coverage I agree to notify Saint John's Health Center and update the insurance information I have on file. I understand and agree that Saint John's University will assume no responsibility for the payment of, or authorization to pay, medical expenses including those that result in injuries that occur while participating in intercollegiate athletics at Saint John's University.

Parent/Guardian Signature and Date

or

Student Signature and Date

Attach a copy of your current insurance card, front and back.

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.

Students are encouraged to discuss this with their parents.