Student Health Evaluation Form

RETURN THIS FORM BY THE AUGUST 1 DEADLINE TO
Health Service, Luther College, 700 College Drive, Decorah Iowa 52101

TO THE STUDENT
Luther College **requires** all students to complete this form as part of admission. **Return this form prior to August 1.**
Your Healthcare provider will need to complete and sign your entrance physical on page 4.

You have been offered admission to Luther College. All information on these pages is considered confidential and protected information and has no effect on your admission status.

Date of entry to Luther (month/year) _____ Entering as: ☐ First-year student ☐ Transfer

IDENTIFICATION (Please complete the entire form in black ink)

Last Name (family) First Name (given) Middle

Home Address

City State ZIP

Country Gender (optional)

Student Cellular Telephone (with area code) Home Telephone (with area code)

Social Security Number Date of Birth

NOTIFY IN EMERGENCY (two (2) phone numbers needed)

Name and Relationship

Home Address of Person to Notify

Cellular Telephone (with area code) Email (home/work, whichever is checked frequently)

Home Telephone (with area code) Work Telephone (with area code)

MEDICAL ALERT CONDITIONS

I have this "Med-Alert" Condition: _____

Ongoing chronic Illnesses: _____

List medication allergies: _____

List other allergies: _____

FAMILY HISTORY

Given Name	Age	Occupation	Age of Death	Cause of death
Father				
Mother				
Siblings (list separately)				

Have any of your relatives (parents/grandparents/sibling) had/have?

	Yes	No	Relationship
Cancer	☐	☐	
High Blood Pressure	☐	☐	
Sickle Cell Trait	☐	☐	
Tuberculosis	☐	☐	
Diabetes	☐	☐	
Kidney Disease	☐	☐	
Heart Disease	☐	☐	
Asthma/Hay Fever	☐	☐	
Seizure Disorder	☐	☐	
Mental Health Disease	☐	☐	
Substance Abuse	☐	☐	
Sudden death <55y.o.	☐	☐	

PERSONAL MEDICAL HISTORY

Answer all questions; comment on all positive answers.

Have you had?	Yes	No
Headache, Migraine	☐	☐
Seizure Disorder	☐	☐
Eye Disease	☐	☐
Ear, Nose, Throat Disease	☐	☐
Asthma	☐	☐
Hay Fever/Seasonal Allergies	☐	☐
Tuberculosis	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Heart Murmur	☐	☐
Anemia	☐	☐
Bleeding/Clotting disorder	☐	☐
Diabetes	☐	☐
Gastrointestinal disease	☐	☐
Gallbladder Disease	☐	☐
Hernia	☐	☐
Urinary Tract Infection	☐	☐
Head Injury/Concussion	☐	☐
LOC/Knocked out	☐	☐
Do you use alcohol/other drugs?	☐	☐
Tobacco use (cigs/E-cigs/smokeless)	☐	☐
Performance Enhancement Supplements)	☐	☐
Kidney Disease	☐	☐
Menstrual Irregularity (female)	☐	☐
Age of Menstruation_____		
Sexually Transmitted Disease	☐	☐
Disease or Injury of Joints	☐	☐
Back Problems	☐	☐
Cancer	☐	☐
Infectious Mononucleosis	☐	☐
Hepatitis	☐	☐
Genetic Disorder	☐	☐
Chronic Fatigue	☐	☐
Anxiety	☐	☐
Depression	☐	☐
Eating Disorder	☐	☐
Learning Disability	☐	☐
Surgery-describe type below	☐	☐
Appendectomy	☐	☐
Tonsillectomy	☐	☐
Fainting/Dizziness with exercise	☐	☐
Chest pain with exercise	☐	☐
Heat Exhaustion/Heat Stroke	☐	☐

Comment on all positive answers, include dates, below.

SCREENING QUESTIONS FOR STUDENT

	Yes	No
1. Do you have physical or learning limitations?	☐	☐
2. Are you now receiving or have you ever received treatment or counseling For mental health illness or substance abuse?	☐	☐
3. Have you had any illness or injury or been hospitalized other than already Noted (give details)	☐	☐
4. Are you taking any medications regularly? (Please list to the right)	☐	☐
5. Do you currently engage in regular exercise?	☐	☐
6. Do you consider your weight to be in a healthy range?	☐	☐
7. Have you traveled outside your native country in the past 12 months? If so where?	☐	☐

Comment on answers, include dates, to the right.

Information disclosed on this form is not released to or shared With other offices on campus.

Confidential Sharing Agreement and Consent For Treatment

The college assures that medical information will be regarded as confidential and shared only as necessary for the student's immediate safety. Health Service will not release medical information to parents unless the student signs a separate release of information specific to each illness/incident.

If a serious illness or accident should occur, and there is concern for the student's safety, every effort will be made to contact parents or guardian. However, in the event that delay in medical or surgical treatment may be detrimental to the health of the student, authorization for consultation and treatment by area physicians is requested. Luther College Health Service recognized the importance of cooperating with the student's family physician, clinic, or hospital in providing health care while the student is enrolled in college. In order to secure or exchange health information, it is necessary to have the permission of the student or parent/guardian if the student is under 18. On occasion, information regarding physical or mental health status of a student may be shared with the vice president for student life or counseling staff if there is a concern for the student's immediate safety or the safety of others. No information will be provided to faculty or work study supervisors without specific consent of the student. Due to new federal regulations regarding confidentiality, additional consents regarding health information will need to be signed at the time the student is seen in Health Service.

Permission is hereby granted to share health information with my family physician, clinic, hospital, vice president for student lifer, or counseling staff if there is a concern for my immediate safety or the safety of others.

_____

Signature of Student Date

_____

Signature of parent/guardian (only needed if student is under age 18) Date

HEALTH INSURANCE

Luther College recommends that students be covered by health insurance and carry an insurance card with them. If you do not have insurance coverage, check with insurance companies in your area. If you would like to obtain coverage from a Decorah-area company, visit *www.luther.edu/healthservice/insurance* for some options. Please make sure your insurance will extend to this area of the country. If you belong to an HMO, be aware of restrictions on medical or pharmaceutical service provided outside your HMO area. Health Service does not direct bill or participate with any insurance companies.

_____

Policy Holder Name **Policy Holder** Birthdate

_____

Policy Holder Address City State ZIP

_____

Policy Holder Employer **Policy Holder** ☐ mother ☐ father ☐ self ☐ other _____

ATTACH A COPY of the front and back of your insurance card.

Please attach a copy of the front of your insurance card here.

Please attach a copy of the back of your insurance card here.

Tuberculosis Screening

In compliance with the American College Health Association's guidelines, Luther College requires TB screening and potential TB testing for all students that are identified as high risk. Please complete the Tuberculosis Screening Form and return with the Student Health Evaluation Form.

Immunizations

Last Name First Name Date of Birth

NOTICE: The remainder of this Student Health Evaluation Form requires an appointment with your health care provider. If your health care provider does not have a complete immunization record and you attended school in the United States, you can obtain the records from your school.

TO THE HEALTH CARE PROVIDER: Measles, Mumps, and Rubella – Two doses required for all students born after December 31, 1956 with dose #1 given at age 12 months or later and dose #2 given at least 28 days after first dose. Lab titers can be done for Rubeola if immunity is questioned.

REQUIRED IMMUNIZATIONS

		month/day/year
MMR (Measles, Mumps,Rubella) 2 doses required	**#1**	
	#2	

		month/day/year
DTP	**#1**	
	#2	
	#3	
	#4	
	#5	

(Primary Series Dates)

		month/day year
POLIO	**#1**	
	#2	
	#3	
	#4	

(Primary Series Dates)

		month/day/year
TD or Tdap (within 10 years)	**#1**	
	#2	

Indicate which was received: ☐ TD or ☐ Tdap

		month/day/year
Meningitis Vaccine	**#1**	
	#2	

(Menactra, Menveo, Menomune): Administered after 16th birthday

REQUIRED TB SCREENING FOR INTERNATIONAL STUDENTS ONLY

(Required Tuberculosis Screening test will be completed at Luther Health Service)

TSPOT: Date collected: _____/_____/_____
Mo. Day Year

Time collected: _____:_____a.m. p.m.
Hour Min.

Result Date: _____/_____/_____ Results: ☐ Positive ☐ Negative
Mo. Day Year

Chest x-ray (if TSPOT positive) Results: ☐ Normal ☐ Abnormal

Date of Chest x-ray _____/_____/_____
Mo. Day Year

IMPORTANT MESSAGE TO STUDENTS

Luther College requires that all students have a current health history, physical, and record of immunizations on file in the Student Health Service Office. **Students not in compliance will experience an administrative hold placed on further registration.**

It is **mandatory** that you enter your own immunizations online: **Please include an official hard copy of your immunizations with this form.** Go to *luther.medicatconnect.com*. Use the Norsekey sign-on and password that you received from Luther to log in.

Luther College will only consider medical exemptions and only after consultation with students and their medical providers and our Medical Director.

MEDICAL EXEMPTION FOR IMMUNIZATIONS

Must also complete and include immunization waiver form from our website 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 _____

USE IMMUNIZATION WAIVER FORM FOR NOTORIZATION FROM OUR WEBSITE.

RECOMMENDED IMMUNIZATIONS

		month/day/year	site	manufacturer	lot #	initials	comments/reactions
HEPATITIS B (indicate if twinrix)	**#1**						
	#2						
	#3						
HEPATITIS A	**#1**						
	#2						
VARICELLA Chicken Pox: Indicate history of or two doses of vaccine	**#1**						
	#2						
INFLUENZA	**#1**						
	#2						
	#3						
	#4						
HPV	**#1**						
	#2						
	#3						
TYPHOID	**#1**						
	#2						
Men B	**#1**						
	#2						
Other							

Tuberculin Skin Test: Date Given: ____/_____/_____ Date Read: _____/_____/_____
Mo. Day Year Mo. Day Year

Interpretation (based on mm of induration as well as risk factors): Induration _____mm ☐ Positive ☐ Negative

Chest x-ray (if above is positive) Results: ☐ Normal ☐ Abnormal Date of chest x-ray: _____/_____/_____
Mo. Day Year

TB test NOT required before entering college

LUTHER COLLEGE
Health Service
700 College Dr.
Decorah, IA 52101

Luther College Comprehensive Entrance Physical and Athletic Pre-Participation Examination

**This form must be completed by an MD, DO, ARNP, or PA.
Other providers will NOT be accepted per NCAA regulations. **

MUST BE COMPLETED WITHIN 12 MONTHS PRIOR TO COLLEGE ENTRANCE (ATHLETES MUST COMPLETE AFTER JUNE 1ST)

Student Name _____ Birthdate _____ Today's date _____

Height _____ Weight _____ Temp. _____ Pulse _____ Resp. _____ BP _____

Vision: ☐ Corrected Lenses ☐ Uncorrected Left eye: _____ Right eye: _____

EXAMINATION

	Normal	Abnormal	Abnormal Findings (numbered and noted)
1. General Appearance	☐	☐	_____
2. Skin	☐	☐	_____
3. Head / Face	☐	☐	_____
4. Eyes	☐	☐	_____
5. Ears	☐	☐	_____
6. Nose & Sinuses	☐	☐	_____
7. Mouth / Teeth / Throat	☐	☐	_____
8. Neck	☐	☐	_____
9. Thorax	☐	☐	_____
10. Breasts	☐	☐	_____
11. Lungs	☐	☐	_____
12. Heart	☐	☐	_____
13. Abdomen	☐	☐	_____
14. Genitalia	☐	☐	_____
15. Rectal	☐	☐	_____
16. Musculoskeletal	☐	☐	_____
17. Lymphatics	☐	☐	_____
18. Blood Vessels	☐	☐	_____
19. Neurological	☐	☐	_____
20. Psychological	☐	☐	_____
21. Depression	☐	☐	_____
22. Anxiety	☐	☐	_____
23. Eating Disorder	☐	☐	_____

24. Drug/Alcohol Use Addressed Please Explain: _____

MANDATORY FOR STUDENT ATHLETES PARTICIPATING IN A VARSITY SPORT

- ☐ **Full Sport Clearance**
- ☐ **Limited Participation (Explain)** _____
- ☐ **No Clearance (Explain)** _____

Recommendations for anxiety, depression, eating disorder, treatment, restriction of academic load or physical activity. Please include period of time for restriction and comments on history.

_____

_____

Are you this student's usual provider? Yes _____ No _____

_____
Health Care Provider's Signature Date

_____
Health Care Provider's Name (Printed)

_____
Street Address City State ZIP

_____
Phone number FAX number

Students: Upon completion of your forms, mail to Health Service, Luther College, 700 College Drive, Decorah, IA 52101.