

Name _____

1. If yes to any questions on page one, explain thoroughly including dates and treatment:

2. Do you have any current restrictions related to above history? ____ Yes ____ No. If yes, explain:
specifically: _____

3. Have you ever had to change occupations for health reasons? ____ Yes ____ No. If yes, explain:

4. Are you currently under a physician's care? ____ Yes ____ No. If yes, indicate for what reason.

5. What medications (prescription and non-prescription) do you currently take? Please list.

MEDICAL RELEASE-CONSENT FOR TREATMENT

In the event a student at the University of St. Francis needs emergency medical treatment, a hospital will not administer treatment without the expressed permission of the student's parents or legal guardian. The University is sending this form to obtain your permission to act in your behalf in the event of any medical emergency.

Please check one:

_____ I do give the University of St. Francis permission to act in my behalf with regard to providing emergency hospital or clinic treatment for myself/son/daughter, and also authorize the University Health Service to arrange or provide for medical care. I hereby waive liability against the University of St. Francis for University provided transportation to hospital, doctors office, clinic or such location as may be necessary and for providing emergency medical care or administering minor medicine provided through the University of St. Francis Health Service.

_____ I do not give the University of St. Francis permission to act in my behalf with regard to providing emergency hospital or clinic treatment for myself/son/daughter, and also do not authorize the University Health Service to arrange or provide for medical care. I do not waive liability against the University of St. Francis for University provided transportation to a hospital, doctor's office, clinic or such location as may be necessary and for providing emergency medical care or administering minor medicine provided through the University of St. Francis Health Service.

Signature of above named student

Signature of closest relative or legal guardian

Telephone number and area code

Today's date

PHYSICAL EXAMINATION

***Required for all students entering the residence halls, Nursing/Allied Health majors, and all athletes.
Exam to be completed not more than 90 days before classes begin.**

To be completed and signed by physician.

Name _____ Date _____
 Height. _____ Weight. _____ B/P _____ P _____ R _____

A. Physician: In the section below, denote whether area is within normal limits (W.N.L.) or abnormal. Record details in the remarks section.

W.N.L.	ABNORMAL		REMARKS
		General Appearance	
		Eyes (include Lids, Pupils, Fundi, E.O.M.)	
		Nose	
		Ears (Hearing Loss)	
		Mouth	
		Throat (include Pharynx, Tonsils)	
		Teeth and Gums	
		Neck (include Carotids and Thyroids)	
		Lymph Nodes (Cervical, Axillary, Inguinal, Epitrochlear)	
		Chest and Lungs	
		Heart (Size, Rhythm, Murmur, Quality of Heart Tones, Thrill)	
		Abdomen (Appearance, Liver, Spleen, Scars, Mass, Tenderness)	
		Hernia (Umbilical, Inguinal, Femoral, Incisional)	
		Extremities (Feet, Edema, Pulses, Range of Motion, Deformity)	
		Skin	
		Rectal	
		Pelvic	
		Back (Attention to list, Pelvic, Tilt, Scoliosis, R.O.M.)	
		Neurological (Include Reflexes)	

- 1) Is the student physically qualified to participate in intramural & varsity sports? ___ Yes ___ No
- 2) Is the student physically qualified to take physical education classes? ___ Yes ___ No
- 3) Is the student found free from communicable disease? ___ Yes ___ No
- 4) Is the student free from medical or emotional conditions requiring current treatment? ___ Yes ___ No
- 5) Should student be checked at Health Services for any specific reason? ___ Yes ___ No
 If Yes, specify _____

Nursing/Allied Health students only:

- 6) Is this student acceptable for clinical participation without restrictions? ___ Yes ___ No
- 7) If student is pregnant, give specific release due to pregnancy and specific restrictions, as appropriate.

IMMUNIZATION HISTORY

Name _____ Date of Birth _____

PLEASE READ CAREFULLY: Illinois law requires incoming students born on or after January 1, 1957 to document proof of immunity to measles, rubella, mumps and tetanus/diphtheria. This may be done by one of the following methods:

- 1) Attach a copy of the student's Certificate of Child Health Examination (obtain from high school health records).
- 2) Provide comparable documentation from prior college or university.
- 3) Provide verification of immunizations taken from the doctor's (MD or DO) records or other health care provider.

IMMUNIZATION: Please provide the month, day, and year for dose administered. The day and month is required if you cannot determine if the vaccine was given prior to the minimum interval or age.

	MO/DAY/YR	MO/DAY/YR	MO/DAY/YR	MO/DAY/YR	MO/DAY/YR
TETANUS/DIPHThERIA) (within last 10 years)					
DIPHThERIA/TETANUS/PER-TUSIS, if International Student, 3 doses required*					
MEASLES (2 doses) OR immunity by lab titre OR confirmed diagnosis					
MUMPS (1 dose) OR immunity by lab titre OR confirmed diagnosis					
Rubella (1 dose) OR immunity by lab titre. Diagnosis of disease is not acceptable.					
OR					
MMR (2 doses) of Measles, Mumps and Rubella					
TB skin test (Mantoux)	Date 1 st test	Result mm	Date 2 nd test	Result mm	Chest x-ray date Result
Varicella/Chickenpox (2 doses) or immunity by lab titre. Diagnosis of disease is not acceptable.					
Hepatitis B (3 doses)					
Meningitis					

Type or print name of physician
(MD office stamp preferred)

Physician Signature

Telephone Number

Date