University of St. Francis
Health Services Department Tower Hall, Room S213
500 N. Wilcox St.
Joliet, IL 60435

STUDENT HEALTH HISTORY

* Please fill out this page prior to appointment with physician**.**

Name_____ Date of Entrance _____/_____/_____

Current Address_____
(Street) (City) (State) (Zip)

Phone Number (___)_____Date of Birth _____/_____/_____ Age_____

Full-time _____ Part-time _____

Is there anyone in your immediate family who has had (please check) Indicate your social habits:

A. FAMILY HISTORY	**Yes**	**No**	**RELATIONSHIP**	**B. SOCIAL HISTORY**	**Yes**	**No**
Diabetes				Smoking		
Hypertension				Alcohol		
Heart Trouble				Drugs		
Cancer						
Hepatitis						
Immune Disorder						
Tuberculosis						
Mental Illness						
Substance Abuse						

C. PAST HISTORY: Do you now have, or have you ever had any of the below (please check yes or no) If yes, explain thoroughly on the following page.

	Yes	**No**		**Yes**	**No**		**Yes**	**No**
Asthma			Recurrent Nausea			Physical Abnormality		
Bronchitis			Recurrent Vomiting			Cancer or Tumors		
Chronic Cough			Hernia			Goiter		
Pneumonia			Chronic Diarrhea			Psychiatric Counseling		
Lung Disease			Colitis			Mental/Emotional Problems		
Shortness of Breath			Diabetes Mellitus			Sexually Transmitted Disease		
Heart Disease			Kidney Disease			Prostate Problems		
Scarlet Fever			Back Pain/Injury			Difficulty Urinating		
Tuberculosis			Eye/Vision Problems			Unintentional Weight loss or Gain		
Stroke			Ear/Hearing Problems			Jaundice		
Low Blood Pressure			Color Blindness			Liver Disease		
High Blood Pressure			Bone/Joint Problems			Hepatitis		
Paralysis			Blood Disorder			Malaria		
Dizziness			Skin Problems			Gallbladder Problems		
Fainting			Rash			Meningitis		
Anemia			***Allergies*** to Medicine, vaccines or food			Abdominal Pain		
Ulcers			Hayfever			Seizures/Convulsions		
Immune Disorder			Medical/Surgical			Fractures/injuries		
Women Only			**Women Only**			**Women Only**		
Irregular Periods			Excessive Flow			Severe Cramps		

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/ IMMUNIZATION HISTORY

***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

Student's Name:

Last **First** **Birth Date:**

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 1st test	Result mm	Date 2nd 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 health care provider

Health Care Provider Signature

Telephone Number

Date