# MEDICAL HISTORY & PHYSICAL REPORT

University Health Services
100 Saint Liam Hall
Notre Dame, IN 46556
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**ALL STUDENTS ARE REQUIRED TO RETURN THIS COMPLETED FORM IN THE ENCLOSED ENVELOPE TO** UNIVERSITY HEALTH SERVICES BY JULY 1ST if enrolling in Fall Semester or *one month prior to enrollment for other semesters.* **PRINT IN ENGLISH WITH INK.**

FOR HEALTH SERVICE USE ONLY: Date Received_____

INCOMPLETE DUE TO: ND ID # _____
Measles #1_____ #2_____
Tetanus_____ TB_____ Mumps #2 ____
Signature: Tx of Minor____
or Meningitis ____
Other_____

COMPLETE_____
ENTERED_____
HOLD ON_____
HOLD OFF _____
Reviewed by Physician_____

NOTIFICATIONS for deficiencies:_____

Class you are entering @ ND: (circle) Fr Soph Jr Sr Grad

If previously attended ND, list last year attended: _____
Name of Program/School _____

Name: _____ Date of Birth _____/_____/_____
(Last) (First) (Middle) Mo. Day Yr

Address: _____ City: _____ State: _____ Zip:_____

Country _____ Country of Origin _____Home Telephone: (_____)_____

Parent/Emergency Contact: _____ Relationship: _____ Telephone: (_____)_____ Cell phone :(_____)_____

## REQUIRED IMMUNIZATIONS Mandated by the state of Indiana – If not complete registration for classes will be delayed.

Documentation may be obtained from your health care provider or previous school records. If documentation is unavailable, re-immunization or blood test (titer) to determine level of Immunity is required.

A. MMR (Measles, Mumps, Rubella) Two doses required if born after 1956. Titer results may be attached in lieu of immunization records.
1. Dose 1 given at age 12-15 months or later # 1 _____/_____/_____ (Month / Day / Year)
2. Dose 2 given at least one month after first # 2 _____/_____/_____ (Month / Day / Year)

B. Tetanus-Diphtheria - Must be within the last 10 years _____/____/_____ (Month / Day / Year) OR Tetanus-Diptheria-Pertussis _____/____/_____ (Month / Day / Year)

C. Meningococcal One dose - preferably at entry into college for freshmen living in dormitories or residence halls who wish to reduce their risk of Meningococcal disease. Any undergraduate who wishes to reduce his/her risk of disease may consider the vaccine.
Received vaccine _____/_____/_____, (Month / Day / Year) OR Student signature (or parent if <18yrs of age) is required if vaccine declined
_____ (Signature) Date_____/____/_____ (Month / Day / Year)

D. Tuberculosis Skin Test (REQUIRED FOR INTERNATIONAL STUDENTS Only AND MUST BE PERFORMED IN THE UNITED STATES.)
*OR Available at University Health Services on arrival to campus.*

Date Given _____/_____/_____ (Month Day Year) Date Read _____/_____/_____ (Month Day Year) Result _____ (Record the actual mm of induration)
Chest X-ray _____/_____/_____ Result of X-Ray _____ *(Attach copy of X-Ray report)* Medications Received_____ From _____/_____ (Month / Year) thru _____/_____ (Month / Year)

## RECOMMENDED IMMUNIZATIONS

E. Hepatitis A - Series of two
Dose #1 _____/_____/_____ (Mo. Day Yr.) Dose #2 _____/_____/_____ (Mo. Day Yr.)

F. Hepatitis B – Series of three.
Dose #1 _____/_____/_____ (Mo. Day Yr.) Dose #2 _____/_____/_____ (Mo. Day Yr) Dose #3 _____/_____/_____ (Mo. Day Yr.)

G. Combined Hepatitis A and Hepatitis B - Three doses needed.
Dose #1 _____/_____/_____ (Mo. Day Yr.) Dose #2 _____/_____/_____ (Mo. Day Yr.) Dose #3 _____/_____/_____ (Mo. Day Yr.)

H. Varicella (Chicken Pox) History of Disease Yes _____ No _____ Date _____/_____ (Mo. Yr.)
Immunization Dose #1 _____/_____/_____ (Mo. Day Yr.) Dose #2 Given at least one month after first dose, if age 13 years or older _____/_____/_____ (Mo. Day Yr.)

I. Other Immunizations _____
_____
_____

*REQUIRED AUTHORIZATION FOR CARE IF STUDENT IS UNDER AGE 18*: I concur with the above and authorize, at the discretion of UHS personnel, medical and surgical care including but not limited to: examinations, treatments, and immunizations for my son or daughter. In the event of serious disease or injury or the need for major surgery, I understand that all reasonable efforts will be made to contact me, but that failure to make contact will not prevent emergency treatment necessary to help preserve life or health.

Parent/Guardian Signature:_____ Date: _____

# COMMUNICABLE DISEASE INFORMATION SHEET

University Health Services (UHS) provides this information in accordance with Indiana State Law. *These vaccines are recommended by the Centers for Disease Control and Prevention (CDC), the American College Health Association (ACHA), American Medical Association (AMA).*

MENINGITIS

*What is Meningitis?* It is an inflammation of the brain and spinal cord
Viral - most common, runs a short uneventful course.
Bacterial – rare but serious and potentially life-threatening. Requires early detection and treatment. 300 Americans die annually.

*How is it transmitted?* It is spread though droplets of respiratory secretions from the infected person.

*Why are college students at risk?* Living in a dorm setting, social behaviors such as sharing eating utensils, etc.

*How can one reduce the risk?* Wash hands frequently, don't share eating utensils, and consider a Menactra Vaccine that has been effective against four strains of the disease. The vaccine will be available at the Health Center. More information at http://uhs.nd.edu.

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MUMPS

*What is Mumps?* It is an acute viral infection with flu-like symptoms. Many complications can arise especially in adult and adolescent patients. The US is experiencing an increase of Mumps. Check with your Health Care provider and verify you have received **two** Mumps vaccines. A blood titer can be drawn to check immunity.

*How is it transmitted?* It is spread by direct contact with respiratory droplet and saliva.

*Why are college students at risk?* It can be spread quickly through a communal living environment such as a dorm.

*How can one reduce the risk?* Two Mumps Vaccines are recommended and are available at UHS.

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HEPATITIS B

*What is Hepatitis B?* It is an infection of the liver caused by the Hepatitis B Virus. It may manifest with flu-like symptoms, jaundice, or no symptoms at all. The Hepatitis B virus can be 100 times more contagious than the AIDS Virus. One in 20 people has or will someday contract Hepatitis B.

*How is it transmitted?* It is transmitted directly or indirectly through infected body fluids.

*Why are college students at risk?* 75% of cases occur between the ages of 15 and 39 years. Activities such as sports, communal living, social behavior, etc. put college students at greater risk.

*How can one reduce the risk?* The Hepatitis B Vaccine is safe and effective. It is a series of three injections over a six month period. The vaccine is available at UHS.

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PERTUSSIS

*What is Pertussis?* It is a highly communicable disease that lasts for many weeks and is typically manifested with severe coughing," whooping" and vomiting. A steady rise has been noted in the US.

*How is it transmitted?* It is spread through direct contact with respiratory droplets from an infected person.

*Why are college students at risk?* Again, communal living and exposure to large populations from all areas of the world.

*How can one reduce the risk?* It is recommended that students receive a TdaP (Tetanus, Diphtheria and adult Pertussis) vaccine as an adolescent or adult 2 - 5 years after their last Td (Tetanus, Diphtheria) booster. The vaccine is available at UHS.

I have read and understood the risks of these diseases and the benefit of vaccination.

Student signature _____ Date _____

University Health Service
University of Notre Dame

*For Health Services Use Only:* ND ID#

**HEALTH QUESTIONAIRE** *(To be completed by student prior to Physical Evaluation by Health Care Provider on reverse side)*

Name: _____ Date of Birth _____/_____/_____

| *Explain all "Yes" answers:* | YES | NO |
|---|---|---|
| 1. Has a doctor ever denied or restricted your participation in a sport for any reason? If YES, explain: | | |
| 2. Do you have any ongoing or chronic medical conditions (like diabetes or asthma)? If YES, explain: | | |
| 3. Are you currently taking any medications (prescriptions, over-the-counter, herbs, vitamins or Supplements)? If YES, list: | | |
| 4. Do you have allergies to any medications, foods, pollens or stinging insects? If YES, list: | | |
| 5. Have you ever passed out or nearly passed out DURING exercise? If YES, explain: | | |
| 6. Have you ever passed out or nearly passed out AFTER exercise? If YES, explain: | | |
| 7. Have you ever had discomfort, pain, or pressure in your chest during exercise? If YES, explain: | | |
| 8. Does your heart race or skip beats during exercise? If YES, explain: | | |
| 9. Has a doctor ever told you that you have (check all that apply): High blood pressure___ A heart murmur___ High Cholesterol ___ A heart infection ___ | | |
| 10. Has a doctor ever ordered a test for your heart (ECG, echocardiogram)? If YES, explain: | | |
| 11. Has anyone in your family died before the age of 50 for no apparent reason? If YES, explain: | | |
| 12. Does anyone in your family have Marfan's syndrome? If YES, explain: | | |
| 13. Have you ever had surgery? If YES, explain: | | |
| 14. Have you ever had a stress fracture? If YES, explain: | | |
| 15. Have you been told that you have, or had, a cervical spine (neck) problem? If YES, explain: | | |
| 16. Do you have asthma or any other lung condition? If YES, explain: | | |
| 17. Were you born without, or are you missing a kidney, an eye, a testicle, or any other organ? If YES, explain: | | |
| 18. Have you had infectious mononucleosis (mono) in the last 6 months? If YES, explain: | | |
| 19. Have you ever had a head injury or concussion, or been confused and lost your memory after being hit in the head? If YES, explain: | | |
| 20. Have you ever had a seizure? If YES, explain: | | |
| 21. Have you ever been unable to move your arms or legs after being hit or falling? If YES, explain: | | |
| 22. When exercising in the heat, do you have severe muscle cramps or become ill? If YES, explain: | | |
| 23. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? If YES, explain: | | |

*FEMALES ONLY*:

24. Have you ever had a menstrual period? □ YES □ NO
25. How old were you when you had your first menstrual period? _____
26. How many periods have you had in the last year? _____

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

Student signature _____ Date _____

*For Health Services Use Only:* ND ID#

Name: _____ Date of Birth _____/_____/_____
Month Day Year

## Physical Evaluation of Student

(To be completed by a health care provider for clearance of the student to participate in the University's physical education program and any travel abroad program, volunteer service program, club sport, intramural sport, and/or participate as a walk-on candidate for a varsity sport. ROTC students may submit their DODMERB physical in lieu of this exam.)

### MEDICAL HISTORY *(Please also review patient questionnaire on previous page)*

_____ No Significant Medical History  Allergies to Medications : ____No ____Yes, List: _____

Other Significant Allergies (foods, bee stings, etc): ___No ____Yes, List _____

Receive Allergy Injections? ___No ____Yes

_____ Routine Prescription Drugs:_____

_____

Please Provide Details or attach documentation of any significant Medical History:

_____

_____

_____

_____

_____

### PHYSICAL EXAM

Blood Pressure _____/_____ Pulse _____ Height_____ Weight _____ (*If applicable*, attach any recent Test Results such as CBC, U/A, Sickle Cell)

| | Nml | Abnml | Comments | | Nml | Abnml | Comments |
|---|---|---|---|---|---|---|---|
| Appearance | | | | Neck | | | |
| Eyes/Ears/Nose/Throat | | | | Back | | | |
| Lymph Nodes | | | | Shoulder/arm | | | |
| Heart | | | | Elbow/forearm | | | |
| Pulses | | | | Wrist/hand | | | |
| Lungs | | | | Hip/thigh | | | |
| Abdomen | | | | Knee | | | |
| Genitalia | | | | Leg/ankle | | | |
| Skin | | | | Foot | | | |

### CLEARANCE

☐ Cleared for participation. Based on my review of the patient questionnaire and my physical exam, this student is presently physically qualified to participate in the University's physical education program, and any travel abroad program, volunteer service program, intramural or club sport, and/or participation in a varsity sport.

☐ Not cleared for participation in : _____ Reason: _____

Recommendations: _____

_____

_____

Name of Health Care Provider: _____ _____
Print/type Signature

Office Address: _____ _____
Date of Physical Exam

_____

_____

_____