WISCONSIN LUTHERAN COLLEGE

HEALTH HISTORY FORM

Must be completed by ALL students

Failure to comply with the Student Health Information Requirements may result in your inability to live on campus, register for classes, and/or compete in athletics.

Name:_____
Last Name First Name Middle Name

Date of Birth:_____ **Gender:** Male _____ Female _____ **Cell Phone:** ( )_____

Home Address: _____
Street City State Zip Code

Emergency Contact Name: _____ **Phone:** ( )_____

Family Physician: _____ **Phone:** ( )_____

PERSONAL HEALTH HISTORY: I have/had the following (check all that apply):

Condition	Dates and comments	Condition	Dates and comments
□ ADD/ADHD		□ Epilepsy/seizures*	
□ Alcohol/substance abuse		□ Heart concerns*	
□ Allergies-seasonal or food		□ Hernia	
□ Anemia		□ Hepatitis*	
□ Anxiety		□ High blood pressure*	
□ Asthma*		□ Joint disease	
□ Blood disorder*		□ Kidney disease*	
□ Bone disease		□ Orthopedic problems	
□ Cancer*		□ Pneumonia	
□ Chicken pox		□ Psychiatric diagnosis	
□ Concussion-head trauma		□ Rheumatic fever	
□ Depression		□ Scarlet fever	
□ Diabetes		□ Skin disease	
□ Diseases of intestinal tract		□ Thyroid condition*	
□ Ear infections		□ Tonsillitis	
□ Eating disorder		□ Other	

*Individuals who report as having a chronic condition (marked with *) must also provide a copy of a recent physical. If you are receiving treatment for any physical or psychological condition, please attach a current plan of care including your provider's name and contact information.*

PERSONAL SYMPTOM HISTORY: I experience the following symptoms (check all that apply):

During Exercise	Dates and comments	Normally	Dates and comments
□ Tire quickly		□ Indigestion	
□ Shortness of breath		□ Spitting up blood	
□ Dizziness		□ Frequent urination	
□ Fainting		□ Eye problems	
□ Chest pain		□ Back problems	
□ Racing heart		□ Frequent headaches	
□ Heart skips beats		□ Weight fluctuations	
□ Heat illness		□ Other	

MEDICATION INFORMATION: I take the following prescription and/or over-the-counter medications or supplements:

Drug Name	Condition	Dosing	Comments

ORTHOPEDIC HEALTH HISTORY: I have/had injuries to the following (check all that apply):

Condition	Dates and type	Condition	Dates and type
□ Spine		□ Pelvis	
□ Shoulder		□ Thigh	
□ Forearm		□ Knee	
□ Elbow		□ Lower leg	
□ Neck		□ Ankle	
□ Wrist		□ Foot	
□ Hand		□ Toes	

FAMILY HEALTH HISTORY: I have/had family members with the following (check all that apply):

Condition	Dates, relation, and comments
□ Cancer	
□ Diabetes	
□ Heart Disease	
□ Kidney Disease	
□ Tuberculosis	
□ Sudden death under age 50	
□ Other	

OTHER HISTORY: Other than that listed above, I have/had the following surgery, illness, or health condition:

_____

I have allergies to these medications: _____

Please check any that apply:

_____ I require vision assistance _____ I require hearing assistance _____ I require academic assistance

_____ I have a medical condition that requires special housing considerations

_____ I have a medical condition that has special dietary concerns

Other comments, concerns, or items to share with the Student Health Center: _____

_____

Student Signature:_____ Date:_____

My signature above indicates that all statements are true to the best of my knowledge. My signature above also permits the Student Health Center to share ***pertinent*** health information with those who have an ***immediate*** need, except where I have indicated below.

DO NOT SHARE INFORMATION ON THIS FORM WITH:

_____Resident Assistant _____ Athletic Staff _____ Director of Student Support _____ Dining Staff

WISCONSIN LUTHERAN COLLEGE

IMMUNIZATION RECORD

Must be completed by ALL students

Students must have required vaccinations or schedule them with the Student Health Center. Those with concerns or objections should contact the Director of Health Services.

Wisconsin State Law (Assembly Bill 344) requires students to sign an acknowledgement statement related to Hepatitis B and Meningitis. Please refer the enclosed Vaccine Information Sheets regarding Hepatitis B and Meningococcal disease.

- My signature below verifies my receipt of the Meningitis and Hepatitis B information statements.
- My signature also indicates that my vaccination history below is true and correct.

REQUIRED VACCINES	Type	Dose	Date (MM/DD/YY)	**RECOMMENDED VACCINES AND TESTS**	Type	Dose	Date (MM/DD/YY)
Diphtheria Tetanus Pertussis (DTP)		1		TB skin test Chest X-ray for reactive TB test or Quantiferon Gold	Reactive _____MM Results	Non reactive	
		2					
		3					
		4					
		5		Hepatitis A		1	
		(6)				2	
Tetanus/Diphtheria (Adult) (TD)	Td	1		Hepatitis B		1	
	Td	2				2	
						3	
		1					
Polio (specify OPV or IPV)		2		Meningococcal		1	
		3				(2)	
		4					
		(5)		Other Vaccines Received			
Measles/Mumps/Rubella (MMR)		1					
		2					
Varicella (Chicken Pox) or date of disease		1					
		(2)					

Student's Name (please print): _____ Date of Birth: _____

Student's Signature: _____ Date: _____

WISCONSIN LUTHERAN COLLEGE

PERSONAL HEALTH INSURANCE FORM

Must be completed for ALL students

INSURANCE INFORMATION:

Insured's Name: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Holder's Relationship to Insured: _____

Employer's Name and Phone: _____

Insurance Company's Name: _____

Insurance Company's Address: _____

Insurance Company's Phone Number: _____

* * * * * * *

Please attach a copy of the front and back of your insurance and/or prescription benefit card(s)

* * * * * * *

PARENTAL CONSENT FOR MINORS UNDER 18 YEARS OF AGE:

The law requires parental permission before medical or surgical treatment of a minor. The hospitals in our area have a similar requirement relative to admission and treatment. If such treatment becomes necessary, every effort will be made to obtain your specific consent before treatment. On occasion you may be unavailable. In order to avoid unnecessary delay, your prior consent to treatment is important. However, no surgical procedures will be performed without your specific knowledge and consent, except in cases of critical emergency.

I understand the considerations set forth above, consent to use of the above insurance policy and authorize any physician and any hospital involved to perform such medical or surgical treatments as me be deemed necessary for my son/daughter.

Signed: _____ Relationship to student: _____

WISCONSIN LUTHERAN COLLEGE

MEDICAL/ORTHO PHYSICAL EXAM FORM

Must be completed by ALL STUDENT-ATHLETES and students who have a chronic condition listed on their Health History Form.

A doctor's Physical Exam Record satisfies WLC's requirements.

Student's Name: _____

Height: _____ Weight: _____

B/P: _____/_____ Pulse: _____

	N	AB	Comments
Head/Face			
Eyes			
Acuity			
Movements			
Fields			
Nystagmus			
Pupils			
Ears			
Nose			
Mouth / Throat			
Tonsils			
Neck			
Nodes			
Thyroid			
Respiratory			
Upper			
Lower			
Cardiovascular			
Rhythm			
Sounds			
Murmurs			
Pulse			
Abdomen			
Genitourinary			
Testicles			
Hernia			
If Indicated Rectal			
Skin			
Neurological Sx			
Concussion Hx			

Based on the preceding evaluation, this athlete is:

□ CLEARED for athletics WITHOUT medical restrictions

□ CLEARED WITH the following medical restrictions:

_____

□ DENIED clearance due to:

_____

NAME of Evaluating Physician (print):

_____

SIGNATURE of Evaluating Physician (sign and date):

_____

R-N	R-AB	L-N	L-AB		Comments
				Head	
				Spine/ Thorax	
				Cervical	
				Thoracic	
				Lumbar	
				Chest/Ribs	
				Shoulder	
				ROM	
				Sternoclavicular	
				Clavicle	
				Acromioclavicular	
				Scapula	
				Glenohumeral	
				Upper Arm	
				Elbow	
				ROM	
				M. Epicondyle	
				L. Epicondyle	
				Radial Head	
				Forearm	
				Wrist	
				Hand and Fingers	
				Thumb	
				Pelvis	
				Sacroiliac	
				Pubis	
				Hip Joint	
				Thigh	
				Quadriceps	
				Hamstring	
				Femur	
				Knee	
				ROM	
				Effusion	
				Lachman	
				Valgus Stress	
				Varus Stress	
				McMurray Test	
				Patella	
				Lower Leg	
				Tibia and Fibula	
				Achilles Tendon	
				Ankle	
				ROM	
				Med/Lat Malleolus	
				Ant. Drawer	
				Foot	
				Midfoot	
				Med. Long Arch	
				Toes	
				Great Toe/ Sesamoid	
				Other Toes	