Student Health Services Information Requirements

As a new student at Wisconsin Lutheran College, you are required to provide the following information. All forms must be on file in the Student Health Center 15 days prior to the start of your semester. Failure to supply the required information will result in a registration hold. Please send appropriate forms to: Wisconsin Lutheran College, ATTN: Health Services, 8800 W. Bluemound Road, Milwaukee WI 53226. Please direct questions to Karen Fischer at 414-443-8549.

1. Health History Form (grey)
   The Health History Form provides information that is kept in your confidential health file in the Student Health Center. This file will be accessed when you seek services in the there and in emergencies. This establishes a baseline of care for the providers in the Student Health Center.

2. Medical/Orthopedic Physical Exam Form (white)
   A medical exam is encouraged for all students, but ***required*** if a chronic medical *condition* exists or if the student is anticipating being an intercollegiate *athlete* at any time during the school year. This exam must be completed by a physician prior to arrival on campus. This record will be kept in your confidential health file in the Health Services and in the case of athletes be shared with the Athletic Director's office.

3. Immunization Record (yellow)
   Each student's immunizations must be documented. ***Required*** immunizations are listed on the Immunization Record and include Measles, Mumps & Rubella (MMR), Diphtheria, Tetanus & Pertussis (DTP) 4 doses and one every 10 years. Many vaccines are recommended and those should also be listed on the Record.

   Immunization records can generally be found at your doctor, high school, grade school, local health office, or state health department. In the State of Wisconsin, for example, you can access your record at the Wisconsin Immunization Registry www.dhfswir.org .

4. Immunization Request Form (pink)
   Any immunizations that are not completed can be done at Health Services upon your arrival to campus by ordering them in advance. Return the Immunization Request Form and applicable deposits with your other forms to arrange for any vaccinations you need or would like. These vaccines are available at no cost and your deposit will be returned one your inoculations are completed.

5. Tuberculosis Questionnaire (orange)
   The Tuberculosis Questionnaire A TB skin test within the past year is required for all foreign born students, individuals who lived in another country for 3 months or those whose answers to the questionnaire require a test. TB tests can also be requested using the Immunization Request Form.

6. Personal Health Insurance Form (blue)
   All full-time students have a health insurance policy with limited coverage in force through the college. This information was sent under separate cover. Please fill out the Personal Health Insurance Form for any other health insurance coverage for which the student is a named beneficiary and provide copies of cards the student will have while at school.

WISCONSIN LUTHERAN COLLEGE

HEALTH HISTORY FORM

ALL students must complete the Health History Form.
Failure to comply with the Student Health Information Requirements may result in your inability to live on campus, register for classes and/or complete in athletics.

Name:_____
LAST FIRST MIDDLE

Date of Birth:_____ **Age**:_____ **Sex**: Male _____ Female _____

S.S. Number: _____ **Cell Phone #** ( )_____

Home Address: _____
Street City State Zip Code

Father's Name: _____ **Phone #** ( )_____

Mother's Name: _____ **Phone #** ( )_____

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

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	

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

Condition	**Dates and type**	**Condition**	**Dates and type**
□ Neck		□ Eating disorder	
□ Shoulder		□ Epilepsy/seizures	
□ Forearm		□ Heart /cardiac concerns	
□ Elbow		□ Hernia	
□ Forearm		□ Hepatitis	
□ Asthma		□ High blood pressure	
□ Blood disorder		□ Joint disease	

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: _____

I require vision aid and need the following accommodations: _____

I require hearing assistance and need the following accommodations: _____

I have a medical condition that requires special housing or dining services accommodations: _____

_____

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

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

_____

_____

Student Signature: _____ Date:_____

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MEDICAL/ORTHO PHYSICAL EXAM FORM

Must be completed for ALL student athletes.
Must be completed by students with chronic conditions listed on the Health History Form
Must be completed by personal physician prior to arrival on campus.

Name:_____
S.S. Number _____
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

_____

_____
Evaluating Physician (print)

_____
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	

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IMMUNIZATION RECORD

Must be completed for ALL students.
Students must have required vaccinations or order them on Immunization Request Form.
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 Hepatitis B and Meningitis information statements.
My signature below also indicates that my vaccination history below is true and correct.

SIGNED_____Date:_____

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

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PERSONAL HEALTH INSURANCE FORM

Must be completed for ALL students.
Information regarding the student health insurance policy was sent in a separate mailing.

INSURANCE INFORMATION:

Insured's Name: _____

Policy Holder Name: _____ Date of Birth: _____

Policy Holder Relationship to Insured: _____

Employer Name and Phone: _____

Insurance Company Name: _____

Insurance Address: _____

Insurance Phone Number: _____

Please provide 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: _____