

This form must be mailed or presented in person by July 15 for August enrollment or by November 30 for January enrollment.

PART-TIME



MARTIN LUTHER COLLEGE

Health Service
Martin Luther College
1995 Luther Court
New Ulm, MN 56073-3300
(507) 354-8221 or (507) 233-9101

STUDENT INSTRUCTIONS: Each student enrolling at MLC is required to submit all personal data, medical history and an immunization record by July 15th. A medical doctor must review the history then complete, date and sign the physical form on page 5. The information within is treated confidentially by the Student Life Department and the Athletic Department. I hereby authorize MLC Health Services to release all medical information as needed to the Student Life Department and the Athletic Department. This consent will automatically expire upon graduation and/or termination from MLC.

Student's signature _____ Date _____

TYPE OR BLOCK PRINT INFORMATION BELOW:

Name _____ Sex: M F

Age _____ Date of birth _____ Marital status: S M D W

Enrolling as: Freshman Sophomore Junior Senior Transfer Special Part time

Home Address _____
Street

_____ City State Zip

Birth Place (Country) _____ Student Cell Phone (____) _____

Athletics you plan to participate in _____

IMMUNIZATIONS

Note: Under the recommendation of the Minnesota Department of Health, the American College Health Association (ACHA), and Martin Luther College (MLC) **requires a 2nd dose of Measles, Mumps, and Rubella (MMR)** for all incoming and transfer students. The ACHA states that all students born after 1956 and entering college should have 2 doses of a live measles vaccine. A blood titer, verified history of the disease, or dates of 1st and 2nd MMR vaccination would meet this requirement. A **Tetanus, Diphtheria, and Pertussis (Tdap) or Td Booster** is required within the last 10 years. If no records are available, vaccination must be obtained. This form includes sections necessary for those seeking **Medical and Conscientious exemption**.

Further information has been sent regarding Hepatitis A, B, and C and Meningitis. The Minnesota Department of Health, ACHA, and MLC recommend the **Hepatitis A & B vaccine series**. The Meningococcal and flu vaccine are recommended but not required. **PROOF OF IMMUNIZATIONS REQUIRED.**

IMMUNIZATION RECORD FOR STUDENTS ATTENDING POST-SECONDARY SCHOOLS IN MINNESOTA

Student Name (Last, First, Middle Initial)	Date of Birth	Soc Security Number (or Student ID#)	Date of Enrollment (Mo/Yr)
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MINNESOTA LAW (M.S. 135A.14) REQUIRES PROOF THAT ALL STUDENTS BORN AFTER 1956 are vaccinated against diphtheria, tetanus, measles, mumps, and rubella, allowing for certain specified exemptions (see below). Any non-exempt student who fails to submit the required information within 45 days after first enrollment cannot remain enrolled. This form is designed to provide the school with the information required by the law and will be available for review by the Minnesota Department of Health and the local health agency.

Check here if you were born before 1957 for the age exemption.

All other students who are not age-exempt: Complete parts 1, 2, 3, and/or 4.

All students: Return this completed form to _____ by _____.

Part 1: Students graduating from a Minnesota high school in 1997 or later			
I have previously met the MMR & Td requirements because I graduated from a Minnesota high school in 1997 or later.			
Student's signature _____		Date _____	
Name of high school:	City:	Date of graduation:	
Part 2: Transfer student from another Minnesota college			
I am exempt from these requirements because my admission records indicate I have met the requirements as an enrolled student in another post-secondary school in Minnesota. Student's signature _____			
Name of previous Minnesota college:		Dates of enrollment: from _____ to _____	
Part 3: Students who graduated from a Minnesota high school prior to 1997 or student from out-of-Minnesota			
Tetanus/diphtheria (Td) (at least one dose required within past 10 years)			
Measles/mumps/rubella (MMR) (at least 1 dose required at 12 mos.)			
I certify that the above information is a true and accurate statement of the dates on which I was vaccinated.			
Student's signature _____		Date _____	
Part 4: Other exemption(s)			
Medical Exemption: The student named above does not have one or more of the required immunizations because he/she has (check all that apply and fill in the appropriate blanks):			
<input type="checkbox"/> a medical problem that precludes the _____ vaccine <input type="checkbox"/> not been immunized because of a history of _____ disease <input type="checkbox"/> shown to have laboratory evidence of immunity against _____			
Physician's signature _____		Date _____	
Conscientious Exemption: I hereby certify by notarization that immunization against _____ is contrary to my conscientiously held beliefs.			
Student's signature _____		Date _____	
Subscribed and sworn to before me this _____ day of _____, 20____.			
Signature of Notary _____			

MUST INCLUDE A COPY OF YOUR IMMUNIZATION RECORD FROM DR. OR STATE REGISTRY.

MEDICAL HISTORY

Have you had any of the following conditions or injuries?

Name: _____

General Conditions	Yes	No	Past	Present	Injuries	Yes	No	Past	Present
Fainting/Dizziness					Toes				
Recurrent Headaches					Feet				
Migraine Headaches					Ankles				
Seizure Disorder/Epilepsy					Lower legs				
Asthma					Knees				
Bronchitis/Pneumonia					Thighs				
Tuberculosis					Hips				
Heart Disease/Disorder					Lower back				
High/Low Blood Pressure					Upper back				
Intestinal Disorder					Ribs				
Stomach Disorder					Abdomen				
Kidney/Bladder Disorder					Chest				
Diabetes					Neck				
Hernia					Fingers				
Cancerous Tumor/Cyst					Hands				
Skin Disorder					Wrists				
Mononucleosis					Forearms				
Depression					Elbows				
Anxiety/Nervousness					Upper arms				
Hearing Impairment					Shoulders				
Drug Allergies					Head				
Environmental Allergies									
Visual Impairment				<input type="checkbox"/> Glasses					
				<input type="checkbox"/> Contacts					
Serious or Significant Illness not above Specify:					Other Specify:				

Latex Allergies Yes No
 Drug Allergies Yes No

Other Allergies: (Food, tape, bees, etc.)

List all Current Medications (Name and reason for taking medication)

LIST ANY OTHER SURGERIES, FRACTURES, ACCIDENTS, OR HOSPITALIZATIONS YOU HAVE HAD			
YEAR	EVENT	YEAR	EVENT

Medical History to be filled out by student and **checked with physician before examination.**
 Please elaborate on any yes answers on lines provided below.

Yes	No	??

1. Has anyone in your family died suddenly, had a heart attack or heart ailment before the age of 50 years?
2. Have you ever passed out, fainted during exercise, or stopped exercising because of dizziness?
3. Do you have asthma (wheezing), shortness of breath, or coughing spells after exercise?
4. Have you ever broken a bone, had an injury to **any** joint or had to wear a cast or brace?
5. Do you have a history of concussion (getting knocked out)?
6. Have you ever suffered a heat-related illness (heat stroke)?
7. Have you had the chickenpox?
 If no, have you had the chickenpox vaccine? _____
8. Do you have anything else to discuss with the doctor?

Additional Comments: _____

Health History Questionnaire

For Males and Females (Questions 1-3)

1. Have you ever been treated for anemia? _____
2. Have you ever been diagnosed as having an eating disorder? _____
3. Have you ever tried to control your weight by vomiting? _____
 Using laxatives? _____ Diuretics? _____ Diet Pills? _____

For Females Only (Questions 1-8)

1. How old were you when you had your first menstrual period? _____
2. When was the longest time between your periods last year? _____
3. How many periods have you had in the last 12 months? _____
4. When was your last period? _____
5. Do you ever have trouble with heavy bleeding? _____
6. Do you ever experience cramps during your period? _____
 If so how do you treat them? _____
7. Do you take birth control pills or hormones? _____
8. When was your last pelvic and/or PAP smear? _____

Please elaborate on any of the questions above. _____

ALL STUDENTS AND ATHLETES NEED TO COMPLETE THIS PAGE IN ITS ENTIRETY

Parents / Legal Guardians / Spouse / Other:

Name _____ Relationship _____

Street _____

City _____ State/Zip _____

In Case of Emergency call (Home) _____ (Work) _____

(Cell) _____ Relationship _____

(Cell) _____ Relationship _____

If different than above, 2nd emergency contact:

Name _____ Relationship _____

Phone (Home) _____ (Work) _____

Phone (Cell) _____

Health Insurance Information No insurance coverage.

Name of company _____

Policy numbers _____ Phone number _____

Address _____ City _____ State/Zip _____

In whose name is the insurance held? _____

Dental Insurance Information No insurance coverage.

Name of company _____

Policy numbers _____ Phone number _____

Address _____ City _____ State/Zip _____

In whose name is the insurance held? _____

Parents:

Please see that your son / daughter has all insurance information regarding health, pharmaceutical, and dental, at college with them. This may be in the form of an insurance card or a copy (front & back) of yours. If it is a copy, please have it laminated.