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

Health Service
Martin Luther College
1995 Luther Court
New Ulm, MN 56073-3300
(507) 354-8221 or (507) 233-9101
Email: friedrck@mlc-wels.edu

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** (____) _____

Student Email Address: _____

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**.
PROOF OF IMMUNIZATIONS REQUIRED.

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 Influenza vaccine are recommended but not required.

Immunization Record for Students Attending Post-Secondary Schools in Minnesota

Students: **Return this completed form to the post-secondary school you will be attending before enrolling.**

Student Name (Last, First, M.I.)	Date of Birth	Student ID Number	Date of Enrollment (Mo/Yr)

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. If you were, you don't have to complete the rest of this form; however you still must return this form to your school.

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

Part 1: *Students graduating from a Minnesota high school in 1997 or later*

I have previously met the MMR (measles, mumps, rubella) and Td (tetanus, diphtheria) 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_____ Date _____

Name of previous Minnesota college:	Dates of enrollment: from _____ to _____

Part 3: *Students who graduated from a Minnesota high school before 1997 or students from out of state*	Mo/Day/Yr	Mo/Day/Yr
Tetanus/diphtheria (Td or Tdap) *(at least one dose required within past 10 years)*		
Measles/mumps/rubella (MMR) *(at least one dose required at or after 12 months of age)*		

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): A physician's signature is required for a medical exemption, and a notary's signature is required for a conscientious exemption*

Medical Exemption: The student named above lacks one or more of the required immunizations because he/she: *(Check all that apply and fill in the appropriate blanks.)*

☐ has a medical problem that precludes the _____ vaccine
☐ has not been immunized because of a history of _____ disease
☐ has laboratory evidence of immunity against _____ disease

Physician's signature _____ Date _____

Conscientious Exemption: I hereby certify by notarization that immunization against

_____ disease is contrary to my conscientiously held beliefs.

Student's signature _____ Date _____

Subscribed and sworn to before me this ____ day of _____, 20____.

Signature of notary _____

MINNESOTA MDH DEPARTMENT OF HEALTH
Immunization Program
651-201-5503 or 1-800-657-3970
www.health.state.mn.us/immunize

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				☐ Glasses					
				☐ 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. _____
_____
_____
_____

PHYSICAL EXAMINATION FOR INCOMING STUDENTS AND ATHLETES

PHYSICIAN INSTRUCTIONS: Martin Luther College requires students to have a recent review of medical history, physical examination, current immunizations, and TB test. Review page 2-4 with student then date, sign, and indicate clearance to compete in Intercollegiate sports, intramurals, or physical education below.

Student's Name _____ Date of Birth _____

Height _____ Weight _____ Pulse _____ BP _____ / _____

Date of last eye examination: _____

	WNL	ABNL	Abnormal findings; write in if deferred.
1. HEAD/EYES	❑	❑	
2. EARS/NOSE/THROAT	❑	❑	
3. MOUTH/TEETH/JAW CONFIGERATION	❑	❑	
4. NECK/THYROID	❑	❑	
5. HEART	❑	❑	
6. CHEST/LUNGS	❑	❑	
7. ABDOMEN	❑	❑	
8. GENITOURINARY	❑	❑	
9. HERNIA	❑	❑	
10. MUSCULOSKELETAL: ROM/ETC	❑	❑	
A. NECK	❑	❑	
B. SPINE	❑	❑	
C. UPPER EXTREMITIES	❑	❑	
D. LOWER EXTREMITIES	❑	❑	
11. NEUROMUSCULAR	❑	❑	
12. SKIN	❑	❑	
13. METOBOLIC/ENDOCRINE	❑	❑	
14. EMOTIONAL/PSYCHOLOGICAL	❑	❑	

Does this person have any physical or learning disabilities? Yes No If yes, please explain. _____

Tuberculin Skin Test (PPD preferred). REQUIRED ONLY FOR HIGH RISK OR FOREIGN BORN INDIVIDUALS.
Date read: _____ _____ m.m. of induration after _____ hours _____ negative _____ positive
Date / Time given: _____ / _____ RFA LFA Date of BCG vaccine _____
DO NOT RETURN UNTIL TEST IS COMPLETE. X-RAY IS REQUIRED WHEN POSITIVE AND APPROPRIATE TREATMENT STARTED. Date and report of x-ray should be within 6 months. Chest x-ray _____

CIRCLE participation recommendations in college sports, intramurals, or physical education.

1. Full participation in all sports.
2. Limited participation in _____
3. Requires clearance from_____ before start of sport.
4. No participation in_____

Be sure immunizations are written on pages 2 and 3 and TB test is completed above.

Physician signature _____ Date _____

Telephone number_____ Address _____

Print Last Name_____ City, State, Zip _____

ALL STUDENTS NEED TO COMPLETE THIS PAGE IN ITS ENTIRETY

Students should carry an insurance card or copy of the card info!

Parents / Legal Guardians / Spouse / Other:

Name _____ Relationship _____

Street _____

City _____ State/Zip _____

Email address: _____

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. **Athletes MUST have insurance.**

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.

Revised 01/14