PHYSICAL AND IMMUNIZATION FORM

Kelsey Horn, RN
Phone: 507-233-9101 ext. 101
Fax: 507-354-8225
hornky@mlc-wels.edu

1995 Luther Court
New Ulm, MN 56073

All students must complete this form and submit it to Health Services.
NO OTHER FORM WILL BE ACCEPTED. Minor students must have the form completed by a parent or guardian.

If attending in fall form is due July 15
If attending in spring form is due November 30

Student Instructions: This is a mandatory form required for registration. The information within is treated confidentially by the Health Services Department. I hereby authorize MLC Health Services to release all medical information as needed to Student Life Department and the Athletic Department. This consent will automatically expire upon graduation and/or termination from MLC.

Athletics you plan to participate in: ____

Student's Signature ____ Date ____________

*Please note, all dates as month/day/year (MM/DD/YY).

LAST NAME | FIRST NAME | MIDDLE INITIAL | AGE

☐ MALE ☐ FEMALE

DATE OF BIRTH (MM/DD/YYYY) | GENDER | EMAIL ADDRESS

PERMANENT ADDRESS | CITY | STATE | ZIP CODE

☐ Foreign Born:

HOME PHONE | CELL PHONE | COUNTRY OF BIRTH

EMERGENCY CONTACT - This is the person we will contact in the event you have a medical emergency at school.

EMERGENCY CONTACT - NAME/RELATIONSHIP | HOME PHONE | CELL PHONE | WORK PHONE

EMERGENCY CONTACT - ADDRESS | CITY | COUNTRY | POSTAL CODE | EMAIL ADDRESS

PERSONAL PHYSICIAN

PERSONAL PRIMARY PHYSICIAN | CLINIC NAME & CITY/STATE | PHONE | FAX

DO YOU HAVE HEALTH INSURANCE? ☐**YES** - CARRY YOUR HEALTH INSURANCE CARD WHILE ON CAMPUS ☐ **NO**
And send a copy of your insurance card with this form.

Consent for Treatment of a Minor (Under 18 years old)
As the parent or legal guardian of a student at Martin Luther College, I hereby give my consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentristy. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent.

PARENT/GUARDIAN SIGNATURE **DATE (MM/DD/YY)**

DO NOT WRITE BELOW THIS LINE

REVIEWED BY: Initials____________________ Date _________________________

☐ Incomplete for:
- ☐ IMMUNIZATIONS
- ☐ MMR
- ☐ Tdap

☐ PE
☐ Medical History ☐ TB Screen/TSpot ☐ Date of PE
☐ Consent ☐ MD Signature ☐ Activity

Notified by: ☐ Letter ☐ Email ☐ Phone ☐ In-Person Initials _______ Date _______

☐ **PE and Immunization Complete:**
Initials __________ Date __________

☐ **Scanned**: Date ________________

IMMUNIZATIONS

Immunization records must be attached to this form.

In order to remain enrolled at MLC, immunization records must be submitted within 45 days of commencement of the academic term for which the student has registered.

NAME OF STUDENT DATE OF BIRTH (MM/DD/YYYY)

(If immune, must include documentation.)

REQUIRED					
MMR (Measles, Mumps, Rubella)	If born on or after 1/1/57, two doses of live MMR vaccine required. **Dose #1** administered on or after 1st birthday. **Dose #2** administered at least 28 days after 1st dose.	Dose #1 __/__/__ MM DD YY	Dose #2 __/__/__ MM DD YY	or Serology Date __/__/__ MM DD YY ☐ Immune	
TETANUS, DIPTHERIA PERTUSSIS	One booster within last 10 years. A single dose of Tdap recommended for all students.	Tdap __/__/__ MM DD YY	Td __/__/__ MM DD YY		
MENINGOCOCCAL VACCINE	1-2 doses, based on age when you receive 1st vaccination.	Dose #1 __/__/__ MM DD YY	Dose #2 __/__/__ MM DD YY	Age at 1st vaccination: ____	
RECOMMENDED					
VARICELLA VACCINE	Two doses, disease date or serology.	Dose #1 __/__/__ MM DD YY	Dose #2 __/__/__ MM DD YY	Disease Date __/__/__ MM DD YY	Serology Date __/__/__ MM DD YY ☐ Immune
HEPATITIS B VACCINE	Series of 3 doses.	Dose #1 __/__/__ MM DD YY	Dose #2 __/__/__ MM DD YY	Dose #3 __/__/__ MM DD YY	
HEPATITIS A VACCINE	Series of 2 doses.	Dose #1 __/__/__ MM DD YY	Dose #2 __/__/__ MM DD YY		
HPV	Series of 3 doses.	Dose #1 __/__/__ MM DD YY	Dose #2 __/__/__ MM DD YY	Dose #3 __/__/__ MM DD YY	

Student Signature **DATE (MM/DD/YY)**

*Yearly Influenza Vaccination Recommended

Medical and Conscientious exemption

A student granted a medical or conscientious exemption may be excluded from all campus activities, including classes, during a disease outbreak. The length of time a student is excluded from campus activities will vary depending on the type of disease and the circumstances surrounding the outbreak, and could range from several days to over a month. A certificate of immunization exemption for medical reasons is valid only when signed by a licensed physician, nurse practitioner, or physical assistant. A conscientious exemption is only valid when notarized.

If you need an exemption form, please contact Nurse Kelsey Horn.

See website for more information on vaccines.

MEDICAL HISTORY

NAME OF STUDENT ______________________ DATE OF BIRTH (MM/DD/YYYY)

Please check box if you have ever had any of the following conditions.

INFECTIOUS DISEASE
- ☐ Chicken Pox
- ☐ Infectious Mononucleosis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Tuberculosis
- ☐ Malaria

EYES, EARS, NOSE, THROAT
- ☐ Wear Glasses/Contact
- ☐ Other Visual Problems
- ☐ Hearing Loss/Deafness
- ☐ Seasonal Allergies
- ☐ Recurrent Sinus Infection
- ☐ Recurrent Ear Infection
- ☐ Recurrent Nose Bleeds

CARDIOPULMONARY
- ☐ Chest Pain with Exercise or Exertion
- ☐ Syncope or Near Syncope
- ☐ Excessive Exertional or Unexplained Shortness of Breath with Exercise
- ☐ Excessive Exertional or Unexplained Fatigue with Exercise
- ☐ Heart Murmur
- ☐ Elevated Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Heart Disease
- ☐ Heart Palpitations or Irregular beat
- ☐ Elevated Cholesterol
- ☐ Marfan Syndrome
- ☐ Congenital Heart Defect
- ☐ Asthma
- ☐ Pneumonia/Bronchitis

G-I
- ☐ Reflux/GERD
- ☐ Ulcer
- ☐ Pancreatitis
- ☐ Gall Bladder Disease
- ☐ Hepatitis Type: ______________
- ☐ Hernia
- ☐ Rectal Bleeding
- ☐ Irritable Bowel
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Hemorrhoids

GENITOURINARY
- ☐ Cystitis/Bladder Infection
- ☐ Blood in Urine
- ☐ Kidney Infection
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Sexually Transmitted Infection

FEMALE
- ☐ Pelvic/Vaginal Infections
- ☐ Pregnancy
- ☐ Breast Lump
- ☐ Painful Periods
- ☐ Irregular Periods
- ☐ Heavy Flow
- ☐ Abnormal PAP Smear

MALE
- ☐ Testicular Lump Testicular
- ☐ Torsion Undescended/Absent
- ☐ Testicle Hydrocele or
- ☐ Varicocele

MUSCULOSKELETAL
- ☐ Arthritis Joint
- ☐ Injury Bone
- ☐ Fractures
- ☐ Scoliosis
- ☐ Back Pain/Problems
- ☐ Osgood-Schlatter
- ☐ Tendinitis
- ☐ Other Musculoskeletal Disorders

HEMATOLOGIC/ONCOLOGIC
- ☐ Anemia
- ☐ Sickle Cell Trait/Disease
- ☐ Leukemia/Lymphoma
- ☐ Hemophilia
- ☐ Immune Deficiency
- ☐ Cancer

NEUROLOGIC
- ☐ ADD/ADHD
- ☐ Seizure Disorder
- ☐ Migraine Headaches
- ☐ Tension Headaches
- ☐ Concussion
- ☐ Head Injury with Loss of Consciousness
- ☐ Other Neurological Disorders

SKIN
- ☐ Eczema
- ☐ Acne
- ☐ Hives
- ☐ Chronic Rash
- ☐ Tattoos/Piercings
- ☐ Other: ______________________

METABOLIC
- ☐ Diabetes Mellitus
- ☐ Thyroid Disorder

MENTAL/EMOTIONAL
- ☐ Anger Management
- ☐ Eating Disorder
- ☐ Drug/Alcohol Dependency/Abuse
- ☐ Depression
- ☐ Panic/Anxiety Disorder
- ☐ Trouble Sleeping
- ☐ Bipolar Disorder
- ☐ Mood Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Schizophrenia
- ☐ Deliberate Self Harm
- ☐ Previous Psychiatric Hospitalization
- ☐ Other: ______________________

OTHER
- ☐ Anaphylactic Reaction
- ☐ Serious Accident/Injury
- ☐ Loss of Paired Organ:
  - ☐ Kidney
  - ☐ Ovary
  - ☐ Eye
  - ☐ Testicle
  - ☐ Other: __________________
- ☐ Other Important Medical History:

____

Do you use tobacco?
☐ No ☐ Yes – packs/day _______

Do you drink alcohol?
☐ No ☐ Yes – amount/week _____

ALLERGIES: ☐ None
- ☐ Allergic to medications
- ☐ Allergic to X-ray dyes
- ☐ Allergic to food/insects/ environmental

Please list all:
____
____
____

SURGERIES: ☐ None
- ☐ Appendectomy ☐ Hernia repair
- ☐ Mole Removal ☐ Ear Tubes
- ☐ Wisdom Teeth Extraction
- ☐ Tonsils/Adenoids
- ☐ Other: (specify below)

____
____
____

MEDICATIONS (including vitamins and supplements):
☐ None

____
____
____
____
____

Additional information you wish to share about your health:

____
____
____
____
____
____

Check whether family members have had any of the following conditions.

Yes	No		Yes	No	
☐	☐	Diabetes ______________________	☐	☐	History of heart problems ______________________
☐	☐	High blood pressure ______________________	☐	☐	Sudden death before age 50 ______________________
☐	☐	Other significant family illness, please describe ______________________			

PHYSICAL EXAMINATION (PE)

TO BE COMPLETED, SIGNED AND DATED BY HEALTHCARE PROVIDER.

NAME ______ DATE OF BIRTH (MM/DD/YYYY) ______ GENDER ☐ MALE ☐ FEMALE

HEIGHT ______ WEIGHT ______ BLOOD PRESSURE ______ PULSE ______

Does the student have any physical or learning disabilities?

☐ No ☐ Yes if yes, explain: ______

TUBERCULOSIS (TB) SCREEN – Required for all students.

1. Does the student have signs or symptoms of active TB disease ☐ YES (go to TB Test) ☐ NO (go to question 2)
2. Is the student a member of a high risk group, or an international students start with IGRA.
   ☐ YES (go to TB Test) ☐ NO (**STOP** No further screening needed)

TB TEST OR

TUBERCULIN SKIN TEST: High Risk (Mantoux only)

Date placed: ____/____/____ (MM/DD/YY) Date read: ____/____/____ (MM/DD/YY)

Result: ____mm of induration

Interpretation based on mm of induration and risk factors:

☐ Negative ☐ Positive (Chest X-ray required)

IGRA: (Specify method) ☐ QFT-G ☐ QFT-GIT ☐ T-SPOT

Date Tested: ____/____/____ (MM/DD/YY)

Result: ☐ Negative
☐ Indeterminate/Borderline (repeat in 6-8 weeks)
☐ Positive (Chest X-Ray required)

Chest X-Ray Date: ____/____/____ (MM/DD/YY) Result: ☐ Normal ☐ Abnormal (explain): ______

Treatment Plan (include information about INH therapy and duration of treatment): ______

CLINICAL EVALUATION	NORMAL	RECORD ABNORMAL FINDINGS
1. Appearance (Report evidence of Marfan Stigmata)		
2. Skin		
3. Head, Ears, Eyes, Nose, Hearing, Visual Acuity		
4. Mouth, Teeth, Gums		
5. Neck and Thyroid		
6. Lungs/Chest		
7. Breasts		
8. Heart (supine and standing)		
9. Pulses (simultaneous femoral and radial)		
10. Abdomen		
11. Genitalia		
12. Back/Spine		
13. Extremities/Musculoskeletal		
14. Neurologic		
15. Emotional/Psychological		
16. Paired Organ Anatomy/Function		
17. Other Findings		

18. Is this student cleared for full physical activity, including participation in intramural, club or intercollegiate sports and able to meet the physical and emotional demands of college life?

☐ YES – Unlimited activity and fit for college ☐ NO – Limited activity Reason: ______

Additional Comments/Recommendations: ______

I have reviewed the medical history and immunizations, conducted the TB screen and examined the student noted above. The information on this physical form is accurate, full and complete to the best of my knowledge. (Please date your signature.)

SIGNATURE OF HEALTH CARE PROVIDER ______ **DATE (MM/DD/YY)** ______

PRINT NAME OF HEALTH CARE PROVIDER ______ **ADDRESS** ______ **PHONE** ______ **FAX** ______