



Report of Health History

This information is strictly for the use of Anderson University Health Services and will not be released without your knowledge or consent. All undergraduate students entering Anderson University are **required** to submit this Report of Health History to the Director of Health Services **prior** to beginning school. The Report of Health History **requires** a physical examination completed by a licensed healthcare provider. It is recommended that a healthcare provider who is familiar with the student and his/her medical history provide the physical examination. **A \$60 fee will be added to the student's account each time services are requested and performed if the Report of Health History is not completed and returned.**

The purpose of this Report of Health History is:

- to provide information in the event of a medical emergency
- to assist the licensed staff of Health Services by providing health information that may not be immediately obtainable from the student
- to assist students who are chronically ill or physically challenged in maximizing their experience at Anderson University.

TYPE OR PRINT IN INK

- Male
 Female

STUDENT'S LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN NAME	DATE OF BIRTH
STREET ADDRESS		CITY	STATE	ZIP
HOME PHONE		BUSINESS PHONE		
FATHER'S NAME	ADDRESS		TELEPHONE	
MOTHER'S NAME	ADDRESS		TELEPHONE	
SPOUSE'S NAME	ADDRESS		TELEPHONE	

Personal History *(to be completed by student)*

Do you currently have trouble with . . . *(Please check yes or no for each.)*

	YES	NO		YES	NO		YES	NO
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Throat	<input type="checkbox"/>	<input type="checkbox"/>	Stomach	<input type="checkbox"/>	<input type="checkbox"/>
Ears	<input type="checkbox"/>	<input type="checkbox"/>	Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Intestines	<input type="checkbox"/>	<input type="checkbox"/>
Nose	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>	Kidneys	<input type="checkbox"/>	<input type="checkbox"/>
Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
						Back	<input type="checkbox"/>	<input type="checkbox"/>
						Muscles/Joints	<input type="checkbox"/>	<input type="checkbox"/>
						Nerves	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>

Have you . . . *(Please check yes or no for each. If yes, please explain.)*

	YES	NO	EXPLANATION		YES	NO	EXPLANATION
Had surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	FEMALES ONLY:	Had menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>
Broken a bone	<input type="checkbox"/>	<input type="checkbox"/>	_____		Had breast problems	<input type="checkbox"/>	<input type="checkbox"/>
Attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>	_____		Been pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Had a seizure	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Had physical activity restricted during the past five years <i>(Give reason and duration.)</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____				
Had any illness or injury or been hospitalized other than already noted	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____				

Have you been diagnosed with or treated for . . . *(Please check yes or no for each.)*

	YES	NO		YES	NO		YES	NO
Headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/depression	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>

Report of Physical Examination *(to be completed by physician)*

INSTRUCTIONS FOR PHYSICIAN:

1. Please review the student's Report of Health History and comment on all positive answers.
2. Complete a physical examination using this form.
3. **Sign this form before returning to student.**

Information provided on this form will not be released without the student's consent, and will only be used for providing health care. Physical examination and tuberculosis test must have occurred within the last twelve (12) months.

Age	_____	yrs.
Height	_____	in.
Weight	_____	lbs.
Temperature	_____	
Pulse rate	_____	
Respiration	_____	
Blood pressure	_____	

Special needs or considerations *(Submit official documentation for approval.)*

Required tuberculosis skin test (mantoux)

Date of test	_____	Site	_____
Date read	_____	Results	_____ mm.
<i>If TB test results exceed 10 mm. of induration, a chest X-ray is REQUIRED.</i>			
Date of X-ray	_____	Results	_____

Are there any abnormalities of the following systems? *(Please check yes or no for each. If yes, please explain.)*

	YES	NO	EXPLANATION		YES	NO	EXPLANATION
Head	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cardiovascular/ Hematological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes (<i>non-acuity</i>)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nose	<input type="checkbox"/>	<input type="checkbox"/>	_____	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____	Metabolic/endocrine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Teeth	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neuropsychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	_____				

Is there loss or serious impaired function of any paired organ?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Is the student now under treatment for a serious medical condition?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Is the student now under treatment for a serious emotional condition?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Do you have any recommendations regarding the care of this student?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Any limitations for physical activity? (<i>recreation, sports, intramurals, etc.</i>)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____

Additional comments *(details not otherwise documented on this form)*

PHYSICIAN'S NAME	SIGNATURE	DATE
STREET ADDRESS	CITY	STATE
		ZIP
		COUNTRY
TELEPHONE	FAX	

Report of Required Immunization

STUDENT: This form should be returned to Anderson University by Aug. 1 to complete your admissions process.

This requirement may be met in one of two ways. **Indicate your preference by checking one of the two boxes below:**

- Have a physician complete this form and return it to you. Then you may return it by mail or deliver it to Student Health Services.
- You may submit a written request for medical or religious exemption. (If this box is checked, an exemption form will be sent to you by mail.)

Student's Statement (to be completed by the student and signed by student and parent/legal guardian)

STUDENT'S LAST NAME	FIRST NAME	MIDDLE INITIAL	MAIDEN NAME
SSN	DATE OF BIRTH		
I authorize Anderson University Student Health Services to release this immunization report to the Indiana Department of Public Health or its designated representative, for compliance audits and in the event of a health or safety emergency.			
STUDENT'S SIGNATURE	DATE		
PARENT/LEGAL GUARDIAN'S SIGNATURE	DATE		

Physician's Statement

(All live vaccines must have been given after 1969, on or after first birthday.)	MO / DAY / YR	MO / DAY / YR	MO / DAY / YR	MO / DAY / YR
A. M.M.R. (MEASLES, MUMPS, RUBELLA): Two doses required. 1. Dose 1, given at age 12-15 mos. or later..... #1 ___/___/___ 2. Dose 2, given at age 4-6 yrs. or later, and at least one month after Dose 1... #2 ___/___/___				
B. TETANUS AND DIPHTHERIA: Primary series with DTaP or DTP and booster with Tetanus-Diphtheria (Td) or Tdap given within the last 10 years meets requirement. 1. Primary series of four doses with DTaP or DTP #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___ 2. Tetanus-Diphtheria (Td) or Tdap Booster given within the last 10 years ... #2 ___/___/___				
C. POLIO: Primary series in childhood meets requirement. Three primary series schedules are acceptable. 1. OPV alone (oral Sabin, three doses) #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___ 2. IPV alone (injected Salk, four doses)..... #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___ 3. IPV/OPV sequential #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___				
D. VARICELLA: History of chicken pox, positive Varicella antibody, or two doses given at least one month apart after age 13 yrs. meets requirement. 1. History of disease <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Varicella antibody <input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive..... 3. Immunization: a. Dose 1..... #1 ___/___/___ b. Dose 2, given at least one month after first dose, if age 13 yrs. or older... #1 ___/___/___	IPV ___/___/___	IPV ___/___/___	OPV ___/___/___	OPV ___/___/___
E. HEPATITIS A: Two doses or positive surface antibody meets requirement. 1. (Recommended) Immunization..... #1 ___/___/___ #2 ___/___/___ 2. Hepatitis A surface antibody..... <input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive..... #1 ___/___/___				
E. HEPATITIS B: Three doses or positive surface antibody meets requirement. 1. Immunization #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ 2. Hepatitis B surface antibody <input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive ___/___/___				
F. INFLUENZA: Annual immunization recommended. ___/___/___				
G. MENINGOCOCCAL: One dose, Quadrivalent polysaccharide vaccine. ___/___/___ Immunization (required for students under age 25). Students with immunodeficiency should be vaccinated every 3-5 years.				
PHYSICIAN'S NAME	SIGNATURE		DATE	
STREET ADDRESS	CITY	STATE	ZIP	TELEPHONE
All records not in English must be accompanied by a certified translation. Please attach a copy of all laboratory results.				