

VITERBO UNIVERSITY STUDENT HEALTH FORM

*****If you are a student athlete and have already completed this form, then please disregard this copy.**

Name (Last/Family)		(First)	(Middle)	Social Security Number
Birth Date: mm/dd/yy ____/____/____	Sex: Male <input type="checkbox"/>	Permanent Address	Phone	Intercollegiate Athlete: Yes or No (circle one)
Age: _____	Female <input type="checkbox"/>			Sport: _____

EXPLANATION OF REQUIREMENTS/ RECOMMENDATIONS

IMMUNIZATION RECORD

MMR (Measles, Mumps and Rubella)	First Dose - Date: ____/____/____	Second Dose - Date: ____/____/____	TWO doses required. Indicate month, day and year for all doses after 12 months of age. Not needed if student born before 1957. Please note if separate vaccines given.	
TD - Tetanus	Most Recent Date: ____/____/____	Primary Series DPT or DTAP Dates:	A booster dose is <u>required</u> within the past 10 years	
Varicella (Chicken pox)	History of disease: Yes <input type="checkbox"/> No <input type="checkbox"/>	First Dose - Date: ____/____/____ Second Dose - Date: ____/____/____	Vaccination is recommended for all students who have not had the disease in childhood	
Polio	Total Number of Doses Received:	Dates:	<u>Required</u> to have a record of vaccination against Polio	
Hepatitis B	First Dose - Date: ____/____/____	Second Dose - Date: ____/____/____	Third dose - Date: ____/____/____	Required for students in clinical health-related studies, but recommended for all students
Meningococcal	Date Dose Given: ____/____/____	***Highly recommended for all incoming freshmen living in dormitories.		
Other Immunizations	Name/Date:	Name/Date:	Name/Date:	List other immunizations and dates received (i.e. BCG, Hepatitis A, Smallpox, Typhoid, etc)

Immunization records may be put into the Wisconsin Immunization Registry? (Please circle one)

YES

NO

(If yes, please sign)

SIGNATURE _____

The Wisconsin Immunization Registry (WIR) is a computerized Internet database application that was developed to record and track immunization dates of Wisconsin's children and adults, providing assistance for keeping everyone on track for their recommended immunizations. The Public may access records at www.dhfwir.org if the information has been put into the program.

TUBERCULOSIS SCREENING

TB Test	TB Skin test (Mantoux) Date applied: _____ Date read: _____ Results: _____ mm <i>**If TB test is positive then a chest x-ray is required</i>	BCG Vaccine: Dates: **International students who have received BCG are required to have a chest x-ray	Chest X-ray Date: Results: MD Signature _____	Recommended within the past 12 months for all students prior to entering the university. May be required for students in clinical health-related, educational and human services studies.
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****International students must attach a copy or statement of TB test or chest x-ray results signed by physician to this form.**

PERSONAL HEALTH HISTORY

Present health: Good _____ Fair _____ Poor _____ Do you smoke? Yes _____ No _____

Vision: Glasses _____ Contacts _____ All the time? _____ Reading only? _____

Are you presently under medical care? Yes _____ No _____ Explain _____

Current medications? Yes _____ No _____ Please List: _____

Allergies (Medications, insects, environmental): Yes _____ No _____ Please List: _____

HISTORY OF ILLNESS

Circle one for the following: Y = yes N = no

Asthma or exercise-induced asthma Y N

Skin problems Y N

Diabetes Y N

Hospitalizations or surgery Y N

Headaches or Migraines Y N

Tuberculosis exposure Y N

Rubella/Mumps/Measles Y N

Dizzy/passed out with exercise Y N

Chest pain Y N

Heart Disease Y N

Cough/sore throat with exercise Y N

Back Trouble Y N

Heart murmur/ high blood pressure Y N

Racing heartbeat/skipped beats Y N

Seizures Y N

Only one of paired organs
(i.e. eyes, kidneys, testicles, etc.)

Heat-related illness Y N
(heat exhaustion or hypothermia)

Head injury Y N

Knocked unconscious Y N

Hearing Deficiency Y N

Kidney Disease Y N

Stinger/burner/pinched nerve Y N

Anemia Y N

Hernia Y N

History anorexia/bulimia Y N

Sudden death of immediate family before age 50 Y N

Have you ever sprained, strained, dislocated, fractured, broken or had repeated swelling or other injuries of any of the following: (Circle)
Head neck shoulder/upper arm elbow/forearm wrist/hand/finger/thumb chest/ribs back pelvis/hip/thigh knee
Lower leg/shin/calf ankle foot/toe

Excessive, unexplained shortness of breath or fatigue with exercise? Y N

Do you use any special equipment such as braces, pads, mouth guards, etc.? Y N

Females only: Regular periods Y N Age at first period _____ Menstrual Difficulty Y N

Explanation of the above "Yes" responses including dates: _____

Family History: _____

EMERGENCY INFORMATION

In Case of Emergency Notify _____
Name Relationship Phone

OR

_____ Name Relationship Phone

Health Care Provider _____
Name Phone

In order to take care of any possible emergency, please sign the permission statement below. If in the opinion of Viterbo University authorities and the attending physician, hospitalization, medical, and/or surgical treatment would be required, I, the undersigned, grant permission for such hospitalization, medical, and/or surgical treatment to be given.

SIGNATURE: _____ DATE: _____
Student

SIGNATURE: _____ DATE: _____
Parent or Guardian if student under 18

Note: If student has a medical condition that we need to be aware of for continuing care, please attach statement by his or her physician to this record.