Summer 2009

Dear New Lake Forest College Student:

Congratulations on your acceptance to Lake Forest College. The Staff at the Health & Wellness Center and Health Services wish you the best of luck in your academic pursuits at the College. The mission of our Health & Wellness Center is to promote the health of each student and the campus community through caring and educating. The Health & Wellness Center provides a range of health and wellness services to all Lake Forest College students with the aim of supporting students in achieving academic and personal excellence. We look forward to welcoming you to campus and serving you over the next four years.

Prior to your enrollment we need information about your health status. Some information is needed to meet requirements of State of Illinois Law (immunizations), to meet Lake Forest College requirements (TB test, health insurance, Meningitis, Hepatitis B), and to assist us in caring for you if you need health services. It is important that you complete the Health History Form and the Immunization Record accurately and **return it by August 5, 2009**. If your forms are not postmarked by August 5, you will be subject to a late fee of $100. Students not in compliance with immunization requirements during their first term of attendance are restricted from registering for subsequent terms until compliance is obtained, per mandate of the State of Illinois.

Before returning the Health History Report and Immunization Record, please make certain the following items are complete:

□ **Lake Forest College Health History Report**
- ◊ All personal information, including parent/guardian and emergency contact information.

□ **Health Insurance Information**
- ◊ Health insurance is mandatory. Provide health insurance information and copy of both sides of insurance card(s), including prescription plans. If you are not covered by your parent/guardian's policy, you must enroll in the Student Health Insurance Plan offered by the College though the Gallagher Koster Insurance Agency (http:www.gallagherkoster.com/).

□ **Immunization Record (Based on State of Illinois Law and College Policy)**
Registration for subsequent semesters will be blocked if you do not comply with immunization requirements.

- ◊ Please consider the recommended vaccinations for HPV, Varicella (chicken pox), Hepatitis A, Polio and Influenza. All vaccines are generally available for a fee to students at Health Services; however, we are not able to bill any medications or immunizations to insurance. It is recommended that you receive your immunizations at your private physician's office prior to your arrival on campus.
- ◊ **Signature** of licensed Health Care provider or certification from health agency or clinic at the end of the Immunization Record.

□ **TB Skin Test**
Lake Forest College policy requires tuberculosis screening for all students. The TB testing evaluation must be completed within one year (12 months) prior to enrollment at Lake Forest College. There is no available waiver for the TB screening.
- ◊ **Signature** of licensed health care provider certifying completion of the TB Skin test.

□ **Medical Consent for Minors**
- ◊ If you will be under the age of 18 when at Lake Forest College, a parent or legal guardian must sign a consent to permit treatment at Health Services.

□ **Medical or Religious Exemptions to Immunization**
- ◊ If applicable, sign the appropriate "Exemption" section.
- ◊ Exemption from immunization may result in quarantine of non-immunized students off grounds in the event of a contagious disease outbreak.

If you feel additional information about your health history would help us in caring for you, please send information on a separate sheet attached to the health record. We hope your move to Lake Forest College goes smoothly, and we look forward to serving you in the future.

Sincerely,

William T. Divane, Psy.D.
Senior Associate Dean of Students
Director of Health & Wellness

HEALTH SERVICES – PART I: HEALTH HISTORY REPORT

555 N. Sheridan Rd. Lake Forest, IL 60045
PHONE (847)735-5050 / FAX (847)735-6284

*(The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. Please attach additional sheets for any items that require fuller explanation. This form must be returned **by August 5, 2009**. If your form is not postmarked by August 5, you will be subject to a late fee of $100)*

1 STUDENT INFORMATION **DATE:**

Student's Name: (Please Print)Last:____________________________ First:___________________ Middle:_____________
Maiden Name/Other:_______________________ Student ID Number:_________________________ Class: FY SO JR SR
Gender: □ Male □ Female Date Of Birth:_______________________ Cell Phone:________________________________
Home Address:____ Home Phone: ______________________________

2 PARENT/GUARDIAN INFORMATION

Name(s)______________________________________Relationship____________Home Phone_______________________
Work Phone(s)_________________________________Cell Phone(s)____
Address_______________________________________City_______________ State/Country__________ Zip__________

3 EMERGENCY CONTACT INFORMATION (In United States)

Name:______________________________ Relationship:____________ Phone Number:____________Cell Phone_____________
Address:____

Physician's Name___________________________________Address____
Phone________________________________ Fax_____________________________

4 INSURANCE INFORMATION (please provide LEGIBLE copy of BOTH SIDES of card)

Insurance Company: ____Policy Number: ______________________________
Name Of Insured_________________________________ Insurance ID #_______________________Group # _______________
Insurance Co.Address____
Street City State Zip Code
Insurance Co. Phone Number____
Prescription Card (if different than above): _______________________________Policy Number:___________________________
Preferred Pharmacy____

5 ALLERGIES/ADVERSE REACTIONS (medications/insect bite/food/latex)

Adverse reaction to:	Year	Type of reaction

6 MEDICATION(S) (Prescription, allergy injections, EpiPen, birth control, over the counter, vitamins, herbal)

Medication:	Taken For:	Dosage:	Frequency:	Date Started:

7 HOSPITALIZATIONS (overnight)

Reason:	Year:	Comments:

8 SURGERIES

Type:	Year:	Comments:

9 SOCIAL HISTORY

Tobacco Use: Cigarette smoking ☐ Current ☐ Past Packs per day ____________ Years smoking __________________
Chewing tobacco, snuff or dip ☐ Current ☐ Past Times per day ____________ Years ________________
Alcohol Use: ☐ Current ☐ Past Type: ☐ Beer ☐ Wine ☐ Hard alcohol Drinks per week _______________
Illicit/Recreational Drugs: ☐ Current ☐ Past Type:______________________________

STUDENT NAME: (Last, First)	
10	**MEDICAL HISTORY**

Do you have a present or past history of (check box of all that apply)

☐ADHD/ADD	☐Eating Disorder (Anorexia/Bulimia/Overeating)	☐ Numbness/tingling of arms/ legs
☐Allergies (seasonal)	☐Eye Problems (besides glasses/contact lenses)	☐Pneumonia
☐Anemia	☐Gallbladder Trouble	☐Rheumatic Fever
☐Arthritis	☐Headache (recurrent)	☐Seizures
☐Asthma/Inhaler use	☐Heart Disease/Problems	☐Sickle Cell Anemia/trait
☐Back Problems	☐Heart Murmur	☐Sinus Trouble
☐Bleeding/Clotting problems	☐HIV	☐Skin Problems/Eczema/Psoriasis/Acne
☐ Blood Pressure (high or low)	☐ Hypoglycemia (low blood sugar)	☐Sleep Problems
☐Broken Bones	☐Intestinal/Stomach Trouble	☐Thyroid Disease
☐Cancer	☐Joint Disease Injury	☐Urinary Tract Infection
☐Cholesterol Elevation	☐Kidney Problems/Stones	☐Other_____________________
☐Diabetes	☐Liver Disease (Hepatitis/Jaundice)	**Females only:**
☐Disability/Handicap	☐ Lymph Node enlargement (chronic)	☐ Irregular menstrual cycles
☐Dizziness/Fainting	☐Meningitis	☐ Abnormal PAP
☐Ear Trouble/Hearing Loss	☐ Mitral Valve Prolapse	☐ Pregnancy
	☐Mononucleosis	☐ Significant premenstrual symptoms

BRIEF EXPLANATION OF ANY MARKED MEDICAL HISTORY

Item	Date	Pertinent Information

11	**MENTAL/PSYCHOLOGICAL HEALTH**

Have you had severe symptoms and/or treatment for: ☐ anxiety; ☐ depression; ☐eating disorder; ☐ mental or emotional disorders; ☐ suicidal thoughts; ☐ suicidal attempts? Please explain and give dates.

12	**FAMILY HISTORY**

	Age	State of Health	(D) Divorced (R) Remarried	Occupation
Mother				
Father				
Sisters				
Brothers				

Have any of your immediate relatives had any of the following	Yes	No	Relationship
Asthma			
Bleeding disorder			
Clotting disorder			
Cancer			
Diabetes			
Seizures			
Heart attack before 55			
Emotional disorder			

Give details of above (including age and cause of death):

Affirmation and consent by student (or parent/guardian, if student under age 18):

(A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the Health & Wellness Center to release information from my or my son/daughter's (if under 18 years of age) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and /or medical care.

(B) I am aware that the Health Services charges for some services and I may be billed through the College Cashier if the account is not paid at the time of visit. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the College is unaffected by the existence of insured coverage.

(C) I am aware that if I am participating in intercollegiate athletics at Lake Forest College my Student Physical Form, Immunization Record, and Insurance Information will be shared with the Lake Forest College Athletic Trainer to ensure that I meet NCAA recommendations prior to my participation in any College sponsored intercollegiate athletic practice or event.

______________________________ ______________
Signature of Student Date

______________________________ ______________
Signature of Parent/Guardian, **if student under age 18** Date

STUDENT NAME (Last, First):

MEDICAL CONSENT FORM FOR MINORS

Dear Parent or Legal Guardian:

The purpose of this consent form is to obtain permission from the parent or legal guardian for Student Health Services to treat a patient who is under the age of 18 and therefore legally a minor. Student Health Services has my permission to treat my minor child (name of child) ____ in the event of a medical emergency. The Student Health Services also has my permission to treat my child for minor injuries and minor illness (including administration of vaccinations such as tetanus, influenza, and/or meningitis).

____	____
Name of Parent/Guardian of Minor (print)	Relationship
____	____
Signature	Date
____	(_____)____________________________________
Street Address	Home Phone
____	(_____)____________________________________
City, State, Zip	Work Phone

EXEMPTIONS TO PRE-ENTRANCE HEALTH IMMUNIZATIONS REQUIREMENTS

MEDICAL EXEMPTION (PHYSICIAN'S SIGNATURE REQUIRED):

(Print Name of Student)___________________________ should be exempt from some or all of the immunization requirements noted on the Lake Forest College Immunization Record and required by the State of Illinois. Administration of the following immunizing agents would be detrimental to this student's health:

____

____

(List Immunizations)

Physician's Signature ____ Date ___________________

RELIGIOUS EXEMPTION

I, (print name)____ wish to be exempt from the immunization requirements noted on the Lake Forest College Immunization Record because administration of immunizing agents conflicts with my religious beliefs.

Please describe the specific religious belief that conflicts with the immunization: (attach additional sheets if necessary)

I release Lake Forest College and their agents and employees from any responsibility for any impairment of my health resulting from this exemption.

Student's Signature ____ Date ______________________

HEALTH SERVICES – PART II: IMMUNIZATION RECORD

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. Enter all information in English.
Registration for next semester will be blocked if all required immunizations are not up to date.

Student Information		
Last Name, First Name	Date of Birth	Date

I. REQUIRED IMMUNIZATIONS	DATE ADMINISTERED (MM/DD/YY)
Tetanus-Diphtheria-Pertussis: Primary series (DTap, DTP, DT or Td) Booster (Tdap or Td) within last 10 years	**Primary Series: (1)** ____/____/____ **(2)** ____/____/____ **3)** ____/____/____ **(4)** ____/____/____ **Tdap Booster**: ____/____/____ (last booster must be within 10 years) **Td Booster**: ____/____/____ (last booster must be within 10 years)
Measles, Mumps, Rubella (MMR): 2 doses required at least 1 month apart **OR ALL 3 OF THESE CRITERIA ARE MET:** **Measles (Rubeola)** **Mumps** **Rubella (German Measles)**	**(1)** ____/____/____ **(2)** ____/____/____ **OR** titer indicating positive immunity ____/____/____ **(1)** ____/____/____ **(2)** ____/____/____ **OR** titer indicating positive immunity ____/____/___ **(1)** ____/____/____ **(2)** ____/____/____ **OR** titer indicating positive immunity ____/____/___ **(1)** ____/____/____ **(2)** ____/____/____ **OR** titer indicating positive immunity ____/____/___
Hepatitis B IMMUNIZATION SERIES	**((1)** ___/___/___ **(2)** ___/___/___ **(3)** ___/___/___ **OR** titer indicating positive immunity ___/___/___
Meningococcal Meningitis: Required for Lake Forest College.	___/____/____ □ Menactra: Meningococcal Polysaccharide Diptheria Conjugate vaccine, Groups A,C,Y and W-135 combined (MCV4). □ Menomune: Meningococcal Polysaccharide vaccine groups A,C,Y and W-135 combined (MPSV4). NOTE: International Students must receive either MCV4 or MPSV4 to meet requirements. Other meningitis vaccinations are not accepted.

II. RECOMMENDED IMMUNIZATIONS	DATE ADMINISTERED (MM/DD/YY)
Hepatitis A IMMUNIZATION SERIES	**(1)** ___/___/___ **(2)** ___/___/___
Twinrix COMBINED HEPATITIS A & HEPATITIS B	**(1)** ___/___/___ **(2)** ___/___/___ **(3)** ___/___/___
Polio	**(1)** ____/____/____ **(2)** ____/____/____ **(3)** ____/____/____ **(4)** ____/____/____
Varicella (chicken pox): Two doses 1 month apart for adults with no history of the disease	**(1)** ____/____/____ **(2)** ____/____/____
HPV Vaccine (Gardasil): Recommended for all females 26 years of age or younger	**1)** ____/____/____ **(2)** ____/____/____ **3)** ____/____/____
Influenza	

III. OTHER VACCINATIONS RECEIVED	DATE ADMINISTERED (MM/DD/YY)
Other (specify):_________________________	**(1)** ____/____/____ **(2)** ____/____/____

IV. HEALTH CARE PROVIDER SIGNATURE	Health Care Provider Contact Information
I certify that this patient has completed the immunizations listed above. Provider Signature:___________________________ Date: ____________________________	______________________________ Street Address ______________ ____________ _______________ City State Zip ____________________ ____________________ Phone Fax

STUDENT LAST NAME, First Name:

V. TB Testing Evaluation (MANDATORY)

Lake Forest College policy requires tuberculosis screening for all students. The TB testing evaluation must be completed within one year (12 months) prior to enrollment at Lake Forest College.
NOTE: There is no available waiver for the TB screening.

- Chest x-rays will be required for all students with a positive or indeterminate TB test and can be performed at Highland Park Hospital, or local health department, or provide documentation of a normal chest film performed within six months prior to arrival at Lake Forest College.
- If you have been treated for latent tuberculosis of for active tuberculosis, please provide documentation on arrival to Lake Forest College. A chest x-ray report will be required.
- INTERNATIONAL STUDENTS: All documents should be presented at International Student Orientation to Student Health Services.

Date Place: ____/____/____ Date Read; ____/____/____ Result (48-72 hours) _____________mm of induration (if no induration, mark “0”	Interpretation ☐ Negative ☐ Positive	If tuberculin skin test is positive (currently or in the past): Chest X-Ray Date: _______________ ☐ Normal ☐ Abnormal (Please describe)
	Treatment ☐ Yes Drug:_____________ Dosage:__________ Frequency: __________ Dates:__________ ☐ No	

I certify that this patient has completed TB testing.

____________________________________ _______________
Health Care Provider Signature Date

____________________________________ ____________________________ ________________ ____________
Street Address City State Zip

______________________ ___________________________
Phone Fax

Please mail all forms to the following address:

Lake Forest College
Health & Wellness Center-Health Services
555 North Sheridan Road
Lake Forest, IL 60045

OFFICE USE ONLY:

Date Received: _________________ Reviewed by/Date:________________

ILLINOIS IMMUNIZATION COMPLIANCE GUIDE
Lake Forest College

Immunization Requirements
Illinois law (Public Act 85-1315) and Lake Forest College policy states: All students born on or after January 1, 1957 enrolling in more than one class at Lake Forest College are required to provide written evidence of immune status with respect to certain communicable diseases or evidence of exemption from this requirement.

Acceptable Proof of Immunity
- Copy of *high school* immunization record (or other schools attended) **or**
- Military or international travel booklet **or**
- Medical physician complete and sign the Lake Forest College Immunization Record **or**
- Attach copies of medical documentation of vaccine information, illness or antibody test results

Date Due: The Immunization Record form must be **returned by August 5, 2009**. If your forms are not postmarked by August 5, you will be subject to a late fee of $100. *Students not in compliance with immunization requirements during their first term of attendance are restricted from registering for subsequent terms until compliance is obtained, per mandate of the State of Illinois.* All forms should be mailed to the following address:

Lake Forest College
Health & Wellness Center-Health Services
555 North Sheridan Road
Lake Forest, IL 60045

Lake Forest College must provide proof of immunity or immunization as follows (per State of Illinois Law and Lake Forest College Policy):

1. Td (Tetanus/Diphtheria):
- 1 booster dose of combined Td *within ten years.*
- Tetanus Toxoid (TT) is NOT acceptable
- Students born outside the U.S. must provide a minimum of 3 doses (DPT/Td) with *at least one* dose within ten years.

2. Measles/Rubeola (aka Hard/Red/10-day)
- Two doses (no less than 1 month apart) administered *after your first birthday* or January 1, 1968 **or**
- Physician diagnosis of disease with specific date **or**
- Copy of approved lab report proving significant level of antibodies for immunity to Rubeola

3. Mumps
- One dose administered after your first birthday AND after January 1, 1968 **or**
- Physician diagnosis of disease with specific date **or**
- Copy of approved lab report proving a significant level of antibodies for immunity to Mumps

4. Rubella (aka German Measles/3-day)
- One dose administered after your first birthday AND after January 1, 1970
- Copy of approved lab report proving a significant level of antibodies for immunity to Rubella
- Note: History of disease is not acceptable for compliance in State of Illinois.

5. Hepatitis B (Required per Lake Forest College Policy)

6. Meningoccal Meningitis (Required per Lake Forest College Policy)
- Menactra: Meningococcal Polysaccharide Diptheria Conjugate vaccine, Groups A,C,Y and W-135 combined (MCV4).
- Menomune: Meningococcal Polysaccharide vaccine groups A,C,Y and W-135 combined (MPSV4).
- NOTE: International Students must receive either MCV4 or MPSV4 to meet requirements. Other meningitis vaccinations are not accepted.

Recommended for U.S. Students Attending 4-Year Colleges/Universities In State Of Illinois (But NOT *REQUIRED* by Lake Forest College or the State of Illinois): Hepatitis A, Polio, HPV, Chicken Pox (Varicella), and Influenza
Note: A pre-entrance physical is strongly recommended but not required by Lake Forest College. All students interested in participating in intercollegiate athletics are **required** to have a pre-entrance physical prior to athletic participation. Please see Part III; Physical Examination Form.

Exemptions:
- Students born prior to 01/01/57.
- Medical Exemption (Requires signed and dated form from a physician stating the specific vaccine(s) contraindicated and duration or medical condition that contraindicates the vaccine(s).
- Religious Exemptions (Requires written, signed and dated statement by the student or parent/guardian if student is a minor, describing his/her objection to immunization based upon bona fide religious tenets and practice).

LAKE FOREST COLLEGE

HEALTH SERVICES – PART III: STUDENT PHYSICIAL EXAMINATION FORM

A Physical Examination is *strongly recommended* for all full-time students, part-time students living in a residence hall, and **REQUIRED** for First Year/Transfer athletes participating in intercollegiate athletics. Please complete this page with your signature at the bottom and have your health care provider review it and complete and sign the next page.

STUDENT INFORMATION	**DATE:**
Student's Name: (Please Print)Last:____________________ First:__________ Middle:__________	
Sport:__________________ Student ID Number:__________________ Class: FY SO JR SR	
Gender: □ Male □ Female Date Of Birth:__________________ Cell Phone:__________________	
Campus Address:____________________________ Home Phone: __________________	

Student Athletic History Form – Please answer the following questions, and bring this with you to your physical examination.

Explain "Yes" answers below.	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Have you ever passed out or nearly passed out **DURING** exercise?		
3. Have you ever passed out or nearly passed out **AFTER** exercise?		
4. Have you ever had discomfort, pain, or pressure in your chest during exercise?		
5. Does your heart race or skip beats during exercise?		
6. Has a doctor ever told you that you have: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
7. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)		
8. Has anyone in your family died for no apparent reason?		
9. Does anyone in your family have a heart problem?		
10. Has any family member or relative died of heart problems or of sudden death before age 50?		
11. Does anyone in your family have Marfan syndrome?		
12. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
13. Have you ever used an inhaler or taken asthma medicine?		
14. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?		
15. Have you had infectious mononucleosis (mono) within the last month?		
16. Do you have any rashes, pressure sores?		
17. Have you had a MRSA skin infection?		
18. Have you ever had a head injury/concussion?		
19. Have you been hit in the head and been confused or lost your memory?		
20. Have you ever had a seizure?		
21. Do you have headaches with exercise?		
22. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		

	Yes	No
23. Have you ever been unable to move your arms or legs after being hit or falling?		
24. When exercising in the heat, do you have severe muscle cramps or become ill?		
25. Do you wear glasses or contact lenses?		
26. Do you wear protective eyewear, such as goggles or a face shield?		
27. Are you happy with your weight?		
28. Are you trying to gain or lose weight?		
29. Has anyone recommended you change your weight or eating habits?		
30. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis that caused you to miss a practice or game?		
31. Have you had any broken or fractured bones or dislocated joints?		
32. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?		
33. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?		
34. Do you regularly use a brace or assistive device?		
35. Do you have any concerns that you would like to discuss with a medical provider?		

Explain "Yes" answers here:

____
____
____
____
____
____
____
____
____
____
____

Signature: ______________________________

STUDENT NAME (Last, First):

Student Physical Examination Form:

DATE OF LAST TETANUS _______________**ALLERGIES** ____
CURRENT MEDICATIONS____
SIGNIFICANT PAST MEDICAL/SURGICAL HISTORY ____
____
____
____

Height__________ Weight __________ BMI (optional) _____
Pulse _____ BP ____/____ (right arm ____/____, left arm ____/____)
Vision R 20/ ____ L 20/____ Corrected: Y N Pupils: Equal ____ Unequal ____

Medical:	Normal	Abnormal Findings
Appearance		
Eyes/ears/nose/throat		
Hearing		
Lymph nodes		
Heart (Auscultation)		
Pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin		
Musculoskeletal:		
Neck		
Back		
Shoulders/arms		
Elbows/forearms		
Wrists/hands/fingers		
Hips/thighs		
Knees		
Legs/ankles		
Feet/toes		

I have examined this student for the following purpose(s):

- ☐ College dormitory residence
- ☐ Collegiate athletic participation (varsity/intramural/club sports)
- ☐ Study abroad

This certifies that the student I have examined is medically qualified as below:

☐ Cleared without restriction
☐ Cleared, with recommendations for further evaluation or treatment for:
____
☐ Not cleared for: ☐ All sports ☐ Certain sports: ____
Reason: ________________________________
Recommendations:____
____

NAME OF PROVIDER ____ **DATE** ___________________________________
ADDRESS____
PHONE____**FAX**____
SIGNATURE OF PROVIDER ____

Please mail all forms to the following address:
Lake Forest College
Health & Wellness Center-Health Services, 555 North Sheridan Road; Lake Forest, IL 60045