LAKE FOREST
COLLEGE

Spring 2015

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 if appropriate, 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 January 12th 2015**. If your forms are not postmarked by January 12, **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.

- **Tuberculosis Screening Questionnaire**
  - ◊ All students must complete the attached tuberculosis screening questionnaire prior to arrival on campus. If any questions are answered affirmatively "yes" then a health care provider must complete the attached tuberculosis risk assessment. If appropriate, TB testing must be completed no earlier than 6 months prior to arrival on campus and prior to registration for second semester.

- **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,

Jennifer L. Jeziorski-Fast, Psy.D.
Interim Director Health and Wellness Center

LAKE FOREST COLLEGE

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 January 13th 2015****. If your form is not postmarked by January 13th 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 Re-admit
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 Never Past Current Packs per day ____________ Years smoking __________________
Chewing tobacco, snuff or dip Never Past Current Times per day ____________ Years ________________
Alcohol Use: Never Current Past Type: Beer Wine Hard alcohol Drinks per week _______________
Illicit/Recreational Drugs: Never 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			
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

Date Received: _________________ Reviewed by/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

LAKE FOREST COLLEGE

HEALTH SERVICES – TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

TO BE COMPLETED BY ALL INCOMING STUDENTS.

Student Information			
Last Name, First Name	Date of Birth	Date	Signature

Please answer the following questions:

Have you ever had a positive TB skin test? Yes No

Have you ever had close contact with anyone who was sick with TB? Yes No

Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years? (If yes, please CIRCLE the country) Yes No

Have you ever traveled* to/in one or more of the countries listed below? (If yes, please CIRCLE the countries) Yes No

Have you ever been vaccinated with BCG? Yes No

If the answer is YES to any of the above questions, a health care provider must complete the tuberculosis risk assessment included in this packet within 6 months prior to the start of classes.

If the answer to all of the above questions is NO, no further testing or further action is required.

** The significance of the travel exposure should be discussed with a health care provider and evaluated.*

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Republic
Chad
China
Colombia
Comoros
Congo
Cook Islands
Côte d'Ivoire
Croatia
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
French Polynesia
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Japan
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libyan Arab Jamahiriya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nepal
Nicaragua
Niger
Nigeria
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Thailand
The former Yugoslav Republic of Macedonia
Timor-Leste
Togo
Tonga
Trinidad and Tobago
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2009. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://apps.who.int/ghodata/?vid=510

HEALTH SERVICES – TUBERCULOSIS (TB) RISK ASSESSMENT

THIS FORM MUST BE COMPLETED BY A HEALTH CARE PROVIDER.

Student Information		
Last Name, First Name	Date of Birth	Date

INSTRUCTIONS: This Risk Assessment Tool is to be completed by a **Health Care Provider in response to a positive (yes) answer on the Tuberculosis (TB) Screening Questionnaire** that every incoming student must complete. If all questions on the Tuberculosis Screening Questionnaire were answered "no" then this form does not need to be completed.

Students with any of the following risk factors should be tested for TB either by Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) blood testing, **unless a previous positive test has been documented**:

Risk Factor:

Recent close contact with someone with infectious TB disease	Yes	No
Foreign-born from (or travel* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America)	Yes	No
Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease HIV/AIDS	Yes	No
Organ transplant recipient	Yes	No
Immunosuppressed (equivalent of > 15 mg/day of prednisone for >1 month or TNF-α antagonist)	Yes	No
History of illicit drug use	Yes	No
Resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facility, nursing home, homeless shelter, hospital, and other health care facility)	Yes	No
Medical condition associated with increased risk of progressing to TB disease if infected [e.g., diabetes mellitus, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal for the given population)]	Yes	No

** The significance of the travel exposure should be discussed with a health care provider and evaluated.*

1. Does the student have signs or symptoms of active tuberculosis disease? Yes _____ No _____

If No, proceed to 2 or 3. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)

A history of BCG vaccination should not preclude tuberculin skin testing of students.

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm. of induration as well as risk factors.)**

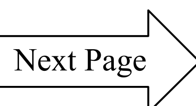
Date Given: ___________ Date Read: _____________

Result: _________ mm of induration **Interpretation: positive____ negative____

Tuberculin Skin Test (TST), if second test performed:

Date Given: ___________ Date Read: _____________

Result: _________ mm of induration **Interpretation: positive____ negative____



TUBERCULOSIS (TB) RISK ASSESSMENT, PAGE 2

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: _________ (specify method) QFT-G QFT-GIT T-spot other_____

Result: Negative____ Positive____ Intermediate____ Borderline____

Interferon Gamma Release Assay (IGRA), if second test performed:

Date Obtained: _________ (specify method) QFT-G QFT-GIT T-spot other_____

Result: Negative____ Positive____ Intermediate____ Borderline____

4. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: _____________ Result: normal____ abnormal_____
If abnormal describe:

****Interpretation guidelines**

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
- Organ transplant recipients
- Immunosuppressed persons: taking > 15 mg/d of prednisone for > 1 month; taking a TNF-α antagonist
- Persons with HIV/AIDS

>10 mm is positive:

- Persons born in a high prevalence country or who resided in one for a significant* amount of time
- History of illicit drug use
- Mycobacteriology laboratory personnel
- History of resident, worker or volunteer in high-risk congregate settings
- Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes

>15 mm is positive:

- Persons with no known risk factors for TB disease

**The significance of the exposure should be discussed with a health care provider and evaluated.*

Physician Certification

I certify that this patient has completed TB risk assessment and testing.

______________________________ ____________
Health Care Provider Signature Date

______________________________ ____________________ ____________ __________
Street Address City State Zip

__________________ ______________________
Phone Fax

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 January 12, 2015**. If your forms are not postmarked by January 12, 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. Return both pages to the Health & Wellness Center – Health Services.

STUDENT INFORMATION
Student's Name: Last:______________________________ First:______________ Middle:___________ Date: ____________
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 gotten very dizzy, passed out or nearly passed out **DURING** exercise?		
3. Have you ever gotten very dizzy, 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, long QT syndrome, or a heart muscle problem (hypertropic or dilated cardiomyopathy)?		
12. Have you ever had excessive or unexpected fatigue with exercise?		
13. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
14. Have you ever used an inhaler or taken asthma medicine?		
15. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?		
16. Have you had infectious mononucleosis (mono) within the last month?		
17. Do you have any rashes, pressure sores?		
18. Have you had a MRSA skin infection?		
19. Have you ever had a head injury/concussion?		
20. Have you been hit in the head and been confused or lost your memory?		
21. Have you ever had a seizure?		
22. Do you have headaches with exercise?		
23. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		

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

Explain "Yes" answers here:

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Signature: ____________________________________

STUDENT NAME (Last, First):	DOB:

Student Physical Examination Form:

DATE OF LAST TETANUS ______________ **ALLERGIES** ______________________________

CURRENT MEDICATIONS____

SIGNIFICANT PAST MEDICAL/SURGICAL HISTORY ______________________________

____

____

SIGNIFICANT FAMILY HISTORY ____

____

REVIEW OF SYSTEMS ____

____

Height__________ Weight __________ BMI (optional) _____
Respiratory Rate ______ Pulse _____ BP ____/____ right arm left arm

Physical evidence of Marfan Syndrome? Yes No

Medical:	**Normal**	**Abnormal Findings**
Appearance		
Eyes/ears/nose/throat		
Hearing		
Lymph nodes		
Heart (Auscultation): **sitting/standing**		
supine		
Pulses: radial and femoral		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin		
Musculoskeletal:		

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

College dormitory residence

Collegiate athletic participation (varsity/intramural/club sports)

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