



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 <u>return it by August 4th 2014</u>. If your forms are not postmarked by August 4th, **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



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 <u>by August 4th 2014</u>. If your form is not postmarked by August 4th you will be subject to a late fee of \$100)

1	STUDENT INFORMATION		DATE:					
	Student's Name: (Please Print)Last:	Student I h:	First: tudent ID Number: Cell Phone: Home Phone:		_ Class: FY SO JR SR	Re-admit		
2	PARENT/GUARDIAN INFORMATION							
2	Name(s)	Rela Cel	Cell Phone(s)					
3	EMERGENCY CONTACT INFORMA	TION (In United	l States)					
	Name:Address:	_ Relationship:	Phone Nu	mber:	Cell Phone			
	Physician's NamePhone	 Fax_	Address					
4	INSURANCE INFORMATION (please	provide LEGIBI	LE copy of BOTH SID	ES of card)				
	Insurance Company:Name Of InsuredInsurance Co.Address	I		Number:	Group #			
	Insurance Co. Phone Number_ Prescription Card (if different than above): Preferred Pharmacy		City State Policy Number:			Zip Code 		
5	ALLERGIES/ADVERSE REACTIONS (medications/insect bite/food/latex)							
	Adverse reaction to:	to: Year			pe of reaction			
_								
6	MEDICATION(S) (Prescription, allergy i			Dosage:		D (G())		
	Medication:	Taken I	Taken For: D		Frequency:	Date Started:		
7	HOSPITALIZATIONS (overnight)							
	Reason:	Year:	Comments:					
8	SURGERIES							
	Type:		Comments:					
9	SOCIAL HISTORY							
	Tobacco Use: Cigarette smoking							

STUD	UDENT NAME: (Last, First)												
10	MEDICAL HI	STORY											
	Do you have a		past his										
	□ ADHD/ADD				☐ Eating Disorder (Anorexia/Bulimia/Overeating)					□ Numbness/ti	ngling o	f arms/	legs
	☐ Allergies (se	easonal)					s (besides glasses/contact lenses)			□Pneumonia			
	□Anemia				Gallbladder Trouble					☐ Rheumatic Fever			
	□Arthritis					Headache (recurrent)				□Seizures			
	□ Asthma/Inh					ease/Proble	ems			☐ Sickle Cell A	\nemia/t	rait	
	☐Back Proble				Heart Mur	mur				☐ Sinus Troub			
	□Bleeding/Cl				\square HIV				☐ Skin Problem	ns/Eczen	na/Psor	iasis/Acne	
	☐ Blood Press		or low)		☐ Hypoglycemia (low blood sugar)					☐ Sleep Proble	ms		
	☐Broken Bones				[ntestinal/	Stomach T	rouble			☐ Thyroid Disc			
	□Cancer					ase Injury				☐ Urinary Trac	t Infecti	on	
	□Cholesterol	Elevation	1			oblems/Sto				Other			
	□Diabetes				Liver Dise	ease (Hepa	titis/Jaundice)			Females only:			
	□Disability/H				Lymph No	ode enlarge	ement (chronic)			☐ Irregular me	nstrual c	ycles	
	□Dizziness/F				Meningiti	S				☐ Abnormal P.	AP		
	□Ear Trouble	/Hearing	Loss		Mitral Va	lve Prolaps	se			☐ Pregnancy			
					Mononucl					☐ Significant p	remenst	rual svr	nptoms
	BRIEF EXPL	ANATIO	N OF A	NY MARI	KED ME	DICAL H	ISTORY		1	<u> </u>			•
	Item			Date			Information						
	10111			Dute		1 011110111	11110111111111						
11	MENTAL/PS	YCHOLO)GICA	L HEALTI	<u> </u>								
	Have you had s	evere svn	notoms	and/or treat	ment for:	anxiety:	☐ depression; ☐ea	ating dise	order: □ n	ental or emotic	onal diso	rders:	
	□ suicidal thou											,	
	_ saletaar aroa;	51110, - 54	reraur ut	itempts. 11	cuse expi	ini una gr	c dates.						
12	FAMILY HIS	TORY											
		Age	State	of Health	(D) Div	orced	Occupation	На	ave any of	your	Yes	No	Relationship
					(R) Rei	married	1			elatives had			•
	Mother								ny of the fo				
	Father								sthma	<u> </u>			
	Sisters								leeding dis	sorder			
	Sisters								lotting dis				
									ancer	51401			
	Brothers								iabetes				
	Diothers								eart attack	hefore 55			
									motional d				
	Give details of	above (in	cluding	age and car	ise of deat	.p).		Li	inotional C	isoruci			
	Give details of	above (III	ciuding	age and cat	isc of ucai	.11).							
Aff	irmation and co	nsent by	student	t (or paren	t/guardia	n, if stude	nt under age 18)	:					
	i iiidioii diid ed	insent by	studen	t (or paren	guar ara	ii, ii staac	in under age 10)	•					
(A)	I have persona	ally suppl	ied (rev	riewed) the	above info	ormation a	nd attest that it is	s true an	d complet	e to the best of	my kno	wledge	. I understand
	that the inforn	nation is s	trictly c	onfidential	and will n	ot be relea	sed to anyone wi	thout my	y written c	onsent, unless	otherwise	e permi	tted by law. If
	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							ness Center to					
	professional involved in providing me (him/her) with emergency treatment and /or medical care.												
(B)										llege Cashier if	the acco	ount is	not paid at the
	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 existen	ce of insu	red cove	erage.	•						•		
(C)					ercollegia	te athletics	s at Lake Forest	College 1	my Studer	nt Physical For	m, Immu	ınizatio	n Record, and
							lege Athletic Trai						
							ractice or event.						- *
	_	•	-		-	•							
	Signature of St	udent				Date	Signature of I	Parent/G	luardian, <u>i</u> t	student under	r age 18	D	ate
	Date Rec	eived.				Revie	wed by/Date:						

UDENT NAME (Last, First):	
MEDIC	CAL CONSENT FORM FOR MINORS
Parent or Legal Guardian:	
	the parent or legal guardian for Student Health Services to treat a patient adent Health Services has my permission to treat my minor child
e event of a medical emergency. The Student Health Servor illness (including administration of vaccinations such a	vices also has my permission to treat my child for minor injuries and is tetanus, influenza, and/or meningitis).
Name of Parent/Guardian of Minor (print)	Relationship
Signature	Date
Street Address	Home Phone
City, State, Zip	Work Phone
	-
(List Immunizations)	_
(List Immunizations) Physician's Signature	
Physician's Signature	Date
Physician's Signature	LIGIOUS EXEMPTION
Physician's Signature	LIGIOUS EXEMPTION
Physician's Signature	LIGIOUS EXEMPTION wish to be exempt from the immunization requirements because administration of immunizing agents conflicts with my religious belie
Physician's Signature	LIGIOUS EXEMPTION wish to be exempt from the immunization requirements because administration of immunizing agents conflicts with my religious belie
REI I, (print name) noted on the Lake Forest College Immunization Record I Please describe the specific religious belief that conflicts	LIGIOUS EXEMPTION wish to be exempt from the immunization requirements because administration of immunizing agents conflicts with my religious belief



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 ADMINI	STERED (MM/DD/	YY)	
Tetanus-Diphtheria-Pertussis:				
Primary series (DTap, DTP, DT or Td)	Primary Series	s: (1)/	(2)/ 3)/ (4)/
Booster (Tdap or Td) within last 10 years	Tiles Desertes	, , ,	Talant In a cartain market In a cartilla (1916)	40
	Td Booster:	//(las	last booster must be within to booster must be within 1	0 years)
Measles, Mumps, Rubella (MMR): 2				
doses required at least 1 month apart	(1)/_	(2)/	_/ OR titer indicating	positive immunity//
OR ALL 3 OF THESE CRITERIA ARE MET:				
Measles (Rubeola)	(1)//	(2)/	_/ OR titer indicating	positive immunity// positive immunity//
Mumps	(1)/	(2)/	_/ OR titer indicating	positive immunity//
Rubella (German Measles)	(1)//	(2)/	_/ OR titer indicating	positive immunity//
Hepatitis B IMMUNIZATION SERIES	(1)/	_(2)/	(3)// OR titer in	ndicating positive immunity//
Meningococcal Meningitis: Required				
for Lake Forest College.				
			saccharide Diptheria Con	jugate vaccine, Groups A,C,Y and W-135
	combined (MC)			
		Meningococcal Po	lysaccharide vaccine grou	ps A,C,Y and W-135 combined
	(MPSV4).	tional Studente mu	est receive either MCV/4 or	MPSV4 to meet requirements. Other
		cinations are not ac		IMPS V4 to meet requirements. Other
			·	
II. RECOMMENDED IMMUNIZATIONS	DATE ADMINI	STERED (MM/DD/	YY)	
Hepatitis A IMMUNIZATION SERIES	(1)/	_ (2)/		
To do ato				
Twinrix COMBINED HEPATITIS A & HEPATITIS B	(1)/	_ (2)/	(3)/	
Polio			_/ (3)/	
Varicella (chicken pox): Two doses 1				
month apart for adults with no history of the	(1)//	(2)/		
disease				
HPV Vaccine (Gardasil):		(2)		
Recommended for all females 26 years of age	1)/	(2)/	/3)/	
or younger Influenza				
III. OTHER VACCINATIONS RECEIVED	DATE ADMINI	STERED (MM/DD/	YY)	
Other	(1)//	(2)/		
(specify):				
	L			
IV. HEALTH CARE PROVIDER SIGNATURE	Health Care P	rovider Contact Ir	nformation	
I certify that this patient has completed the				
immunizations listed above.				
	Street Address	3		
Provider				
Signature:	City		7:	
	City	State	Zip	
Date:				
	Phone		Fax	



Student Information

HEALTH SERVICES – TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

TO BE COMPLETED BY ALL INCOMING STUDENTS.

Last Name, First Name		Date of Birth	Date	Signature				
Please answer the follo	wing 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 vacc	cinated with BCG?			Yes □No				
	any of the above question		er must complete the tube	rculosis risk assessment				
included in this packet wi	thin 6 months prior to the st	art of classes.						
If the answer to <u>all</u> of th	e above questions is NO,	no further testing or fu	rther action is required.					
* The significance of the	travel exposure should be a	liscussed with a health	care provider and evaluat	ed.				
Afghanistan	Cook Islands	Kazakhstan	Niger	Swaziland				
Algeria	Côte d'Ivoire	Kenya	Nigeria	Syrian Arab Republic				
Angola	Croatia	Kiribati	Pakistan	Tajikistan				
Argentina	Democratic People's	Kuwait	Palau	Thailand				
Armenia	Republic of Korea	Kyrgyzstan	Panama	The former Yugoslav				
Azerbaijan	Democratic Republic of	Lao People's	Papua New Guinea					
Bahrain	the Congo	Democratic Repub		Timor-Leste				
Bangladesh	Djibouti	Latvia	Peru	Togo				
Belarus	Dominican Republic	Lesotho	Philippines	Tonga				
Belize	Ecuador	Liberia	Poland	Trinidad and Tobago				
Benin	El Salvador	Libyan Arab	Portugal	Tunisia				
Bhutan	Equatorial Guinea	Jamahiriya	Qatar	Turkey				
Bolivia	Eritrea	Lithuania	Republic of Korea					
Bosnia and	Estonia	Madagascar	Republic of Moldo					
Herzegovina	Ethiopia	Malawi	Romania	Uganda				
Botswana	French Polynesia	Malaysia	Russian Federation					
Brazil	Gabon	Maldives	Rwanda	United Republic of				
Brunei Darussalam	Gambia	Mali	Saint Vincent and					
Bulgaria	Georgia	Marshall Islands	Grenadines	Uruguay				
Burkina Faso	Ghana	Mauritania	Sao Tome and Prin	ncipe Uzbekistan				
Burundi	Guam	Mauritius	Senegal	Vanuatu				
Cambodia	Guatemala	Micronesia	Serbia	Venezuela (Bolivarian				
Cameroon	Guinea	(Federated States of	of) Seychelles	Republic of)				
Cape Verde	Guinea-Bissau	Mongolia	Sierra Leone	Viet Nam				
Central African	Guyana	Montenegro	Singapore	Yemen				
Republic	Haiti	Morocco	Solomon Islands	Zambia				
Chad	Honduras	Mozambique	Somalia	Zimbabwe				
China	India	Myanmar	South Africa					
Colombia	Indonesia	Namibia	Sri Lanka					
Comoros	Iraq	Nepal	Sudan					
Congo	Japan	Nicaragua	Suriname					
			Summing					

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2009. Countries with incidence rates of \geq 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	Data of Birth	Data	4					
Last Name, First Name	Date of Birth	Date						
INSTRUCTIONS: This Risk Assessment Tool is to be completed by a <u>Health Care Provider</u> 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.								
		se Assay (IGRA) blood testing,	x					
Risk Factor:								
Recent close contact with someone with infectious T	B disease		☐ Yes	□ No				
Foreign-born from (or travel* to/in) a high-prevalence Europe, or Central or South America)	e area (e.g., Africa, Asia	a, Eastern	□ Yes	□ No				
Fibrotic changes on a prior chest x-ray suggesting in	active or past TB disea	se HIV/AIDS	☐ Yes	□ No				
Organ transplant recipient			☐ Yes	□ No				
Immunosuppressed (equivalent of > 15 mg/day of pro	ednisone for >1 month	or TNF-α antagonist)	☐ Yes	□ No				
History of illicit drug use			☐ Yes	□ No				
Resident, employee, or volunteer in a high-risk congracility, nursing home, homeless shelter, hospital, and			□ Yes	□ No				
Medical condition associated with increased risk of p mellitus, silicosis, head, neck, or lung cancer, hemate Hodgkin's disease or leukemia, end stage renal disemalabsorption syndrome, low body weight (i.e., 10%)	ologic or reticuloendoth ase, intestinal bypass o	elial disease such as or gastrectomy, chronic	□ Yes	□ No				
* The significance of the travel exposure should be d	liscussed with a health	care provider and evaluated.						
1. Does the student have signs or symptoms of a If No, proceed to 2 or 3. If Yes, proceed with additional evaluation, and sputum evaluation as indicated.			culin skin te	esting, chest				
2. Tuberculin Skin Test (TST) A history of BCG vaccination should not preclude (TST result should be recorded as actual millimeters (mm) of should be based on mm. of induration as well as risk factors.	of induration, transverse d		he TST in	terpretation				
Date Given: Date Read:								
Result: mm of induration **Interpretation	on: positive negati	ve						
Tuberculin Skin Test (TST), if second test performed								
Date Given: Date Read:								
Result: mm of induration **Interpretation	on: positive negativ	/e						



TUBERCULOSIS (TB) RISK ASSESSMENT, PAGE 2

3. Interferon Gamma Release Assay (IGRA)

Phone

Fax

Date Obtained: (specify method)	QFT-G	G QFT-GIT T-spot other	_					
Result: Negative Positive Intermed	ediate	Borderline						
Interferon Gamma Release Assay (IGRA), if sec	ond test per	ormed:						
Date Obtained: (specify method)	Date Obtained: (specify method) QFT-G QFT-GIT T-spot other							
Result: Negative Positive Intermed	ediate	Borderline						
4. Chest x-ray: (Required if TST or IGRA is po	sitive)							
Date of chest x-ray: Result: normal abnormal lf 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	Si	tate	Zip				



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 <u>returned by August 4th 2014</u>. If your forms are not postmarked by August 4th, 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).



or lost your memory?
21. Have you ever had a seizure?

falling?

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

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.

ST	UDENT INFORMATION						$\overline{}$
	dent's Name: Last:		First:		Middle: Date:		
Sno	ort: Student ID Num	hor	1.1181		Class: FV SO ID SD		
Spo	ort: Student ID Num nder: Male Female Date Of Birth:	ibei			Class. F1 SO JK SK		
Con	many Address.			Come Dhomes			
Cai	mpus Address:			п	ome Phone:		
	dent Athletic History Form – Please answ mination.	er th	e follow	ving quest	ions, and bring this with you to your ph	ıysical	I
Exp	lain "Yes" answers below.	Yes	No			Yes	No
	Has a doctor ever denied or restricted your			24. H	ave you ever been unable to move your arms or		
	participation in sports for any reason?			le	gs after being hit or falling?		
2.	Have you ever gotten very dizzy, passed out or			25. W	hen exercising in the heat, do you have severe		
	nearly passed out DURING exercise?				uscle cramps or become ill?		
3.	Have you ever gotten very dizzy, passed out or				o you wear glasses or contact lenses?	1	1
٥.	nearly passed out AFTER exercise?				o you wear protective eyewear, such as goggles	1	1
4.	Have you ever had discomfort, pain, or pressure in				r a face shield?		
٦.	your chest during exercise?				re you unhappy with your weight?	1	
5.	Does your heart race or skip beats during exercise?				re you trying to gain or lose weight?	1	1
6.	Has a doctor ever told you that you have:		 		as anyone recommended you change your	1	+
0.	☐ High blood pressure ☐ A heart murmur				eight or eating habits?		
	-				ave you ever had an injury, like a sprain, muscle	1	1
	☐ High cholesterol ☐ A heart infection				r ligament tear, or tendinitis that caused you to		
7.	Has a doctor ever ordered a test for your heart?				iss a practice or game?		
	(for example, ECG, echocardiogram)				ave you had any broken or fractured bones or	1	
8.	Has anyone in your family died for no apparent				slocated joints?		
	reason?				ave you had a bone or joint injury that required	1	1
9.	Does anyone in your family have a heart problem?				rays, MRI, CT, surgery, injections, rehabilitation,		
10.	Has any family member or relative died of heart				nysical therapy, a brace, a cast, or crutches?		
	problems or of sudden death before age 50?				ave you been told that you have or have you had	1	1
11.	Does anyone in your family have Marfan				n x-ray for atlantoaxial (neck) instability?		
	syndrome, long QT syndrome, or a heart muscle				o you regularly use a brace or assistive device?	1	1
	problem (hypertropic or dilated cardiomyopathy)?				o you have any concerns that you would like to	†	†
12.	Have you ever had excessive or unexpected fatigue				scuss with a medical provider?		
	with exercise?			<u> </u>	and the second second	1	-
13.	Do you cough, wheeze, or have difficulty breathing			F1.	oin "Vaa" ongwara bara		
	during or after exercise?			Expla	ain "Yes" answers here:		
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						

Signature:

STUDENT NAME (Last, First):	DOB:
Student Physical Examination F	Form:
DATE OF LACT TETANIC	ALLED CIES
	ALLERGIES
CURRENT MEDICATIONS	
SIGNIFICANT PAST MEDICAL/SUI	RGICAL HISTORY
SIGNIFICANT FAMILY HISTORY	
REVIEW OF SYSTEMS	
Height Weight Respiratory Rate Pulse	BMI (optional) BP/ □ right arm □ left arm
Physical evidence of Marfan Syndrome?	
Medical: Non	rmal 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 folloon College dormitory residence Collegiate athletic participation	owing purpose(s): on (varsity/intramural/club sports)
This certifies that the student I have exa ☐ Cleared without restriction ☐ Cleared, with recommendation	ns for further evaluation or treatment for:
□ Not cleared for: □ All sports	s Certain sports:
Reason:	
Recommendations:	
NAME OF PROVIDER	DATE
ADDRESS	
	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