

This form is required to be completed no earlier than six months prior to arriving on campus for first year students and no earlier than twelve months prior to arriving on campus for transfer students. Portions as marked must be completed by your healthcare professional. This information will be used by Northland College Health Services, Northland College Outdoor Orientation, Northland College Residential Life, Northland College Athletic Training, and collaborating physicians as a background for providing healthcare and making recommendations to college-sponsored trip leaders or coaches. Information disclosed will not affect your status as a student. No part of this record will be otherwise released without written client permission, except in cases of emergency.

INSTRUCTIONS

- 1) Section one (pages 1-2) should be completed by the student (or parent/guardian if student is less than 18 years old). If the student's Northland College ID number is unknown, that space may be left blank. Otherwise, the section one must be completed in its entirety.
- 2) Section two (pages 3-5) should be completed by a physician at the time of a physical scheduled within the guidelines above.
- 3) A clear and legible copy of the front and back of the insurance card covering the student **must be submitted with this form.**

SECTION ONE

STUDENT INFO

LAST NAME _____ FIRST NAME _____ M.I. _____
 PREFERRED NAME _____ CELL PHONE (_____) _____ - _____
 NC ID _____ NC EMAIL _____

Northland College Health Services recommends the below immunizations for the college population. The State of Wisconsin requires private colleges to affirm whether students living on-campus have received the Hepatitis B and Meningococcal vaccinations. Waivers are granted for documented health reasons, reasons of personal conviction or religious conviction (on reverse). Contact Northland College Health Services with any concerns or questions about this requirement. Please review the information on these diseases and the vaccination recommendations on the Northland College incoming student webpage. Complete the spaces below as fully as possible. **Do not attach a separate sheet.** In the event that you have not received these vaccinations and are interested in receiving them, please contact your primary physician or contact Health Services at Northland College after you arrive on campus to arrange an appointment with our physician here.

IMMUNIZATIONS

MMR (measles, mumps, rubella)	Date of first dose	Date of second dose	
Td (Tetanus-Diphtheria) or T-dap (Tetanus-Diphtheria-Pertussis)	Date of most recent dose	Circle one: Td T-dap	
Meningitis	Date of first dose	Date of second dose	Circle one: Menomune Menactra Menveo
Hepatitis A	Date of first dose	Date of second dose	
Hepatitis B	Date of first dose	Date of second dose	Date of third dose
HPV/ Gardasil	Date of first dose	Date of second dose	Date of third dose
Varicella / Chicken Pox	Date of first dose	Date of second dose	OR circle if history of chicken pox YES
Influenza	Date of most recent dose		

Student (or parent/guardian if student is under 18 years of age) acknowledges that they have received and reviewed the information provided by Northland College on the topics of Hepatitis B and Meningococcal Disease (on the Northland College incoming students webpage) and the availability and effectiveness of vaccinations for each of these diseases. Student understands that it is their responsibility to provide Northland College with a record of immunization dates or a document of waiver due to health, personal or religious convictions (on reverse). Student understands that this documentation will remain confidential, except in the event of a health emergency.

Initial to acknowledge _____ (student or parent/guardian of minor student)

Date _____

SECTION ONE CONTINUED

VACCINE WAIVER

Northland College allows for the waiver of the Hepatitis B and Meningococcal Disease vaccines for reasons of medical, personal, or religious conviction. The waiver must be completed each year that the student lives on-campus and is to be completed by an individual (or parent/guardian if student is under the age of 18) waiving Meningococcal and Hepatitis B vaccination.

Student (or parent/guardian if student is under the age of 18) has have received and read the information in the Meningococcal/Hepatitis B Diseases Fact Sheet from the college about Meningococcal and Hepatitis B diseases and the effectiveness and availability of the vaccines (available on the Northland College incoming students webpage). Student (or parent/guardian if student is under the age of 18) acknowledges that the diseases are rare but potentially life threatening. Students (or parent/guardian if student is under the age of 18) understands that Northland College (in accordance with Wisconsin Law) requires that an individual living on-campus at Northland shall affirm proof of vaccination against Meningococcal and Hepatitis B diseases unless a waiver is signed. Student (or parent/guardian if student is under the age of 18) chooses to waive receipt of Meningococcal and Hepatitis B vaccines for the above named person. Student (or parent/guardian if student is under the age of 18) voluntarily agrees to release, discharge, indemnify and hold harmless Northland College, its officers, employees and agents from any and all costs, liabilities, expenses, claims, demands, or causes of action on account of any loss or personal injury that might result from the student’s (or parent’s/guardian’s if student is under the age of 18) decision not to have the student immunized against meningitis and/or Hepatitis B. Student (or parent/guardian if student is under the age of 18) realizes that in, the event of an outbreak, this student may be quarantined or asked to temporarily leave campus, at the discretion of the Ashland County Public Health Department.

Signature of student: _____ Date: _____

Signature of parent/guardian: _____ Date: _____
(if student is under the age of 18)

SICKLE CELL TRAIT TEST WAIVER

Sickle Cell Trait is a common condition (>3 million Americans). Sickle Cell Trait is an inherited condition of the oxygen-carrying protein, hemoglobin, in the red blood cells. Although Sickle Cell Trait is most predominant in African-Americans and those of Caribbean, Indian, Mediterranean, Middle Eastern, and South and Central American ancestry, persons of all races and ancestry may test positive for Sickle Cell Trait. Sickle Cell Trait is usually benign, but during intense, sustained exercise, hypoxia (lack of Oxygen) in the muscles may cause sickling of red blood cells (red blood cells changing from a normal disc shape to a crescent or “sickle” shape). This can cause accumulation of red blood cells in the bloodstream and “logjam” blood vessels leading to collapse from the rapid breakdown of muscles starved of blood and Oxygen. The NCAA has mandated that all student-athletes have knowledge of their Sickle Cell Trait status before they participate in any intercollegiate athletic events, including strength and conditioning sessions, practices, competitions, etc.

Student (or parent/guardian if student is under the age of 18) understands and acknowledge that the NCAA and the Northland College Athletic Department mandate that all student-athletes have knowledge of their Sickle Cell Trait status. Additionally, student (or parent/guardian if student is under the age of 18) has read and fully understands the aforementioned facts about Sickle Cell Trait and Sickle Cell Trait testing. Student (or parent/guardian if student is under the age of 18) recognizes that their true physical condition is dependent upon an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries, ailments, and/or disabilities experience, and hereby affirms that student (or parent/guardian if student is under the age of 18) has fully disclosed in writing any prior medical history and/or Sickle Cell Trait status to the Northland College Athletic Training staff. Student (or parent/guardian if student is under the age of 18) does not wish to undergo Sickle Cell Trait testing as part of the pre-participation physical examination and voluntarily agrees to release, discharge, indemnify, and hold harmless Northland College, its officers, employees, and agents from any and all costs, liabilities, expenses, claims, demands, or causes of action on account of any loss of personal injury that might result from non-compliance with the mandate of the NCAA and the Northland College Athletic Department. Student (or parent/guardian if student is under the age of 18) has read and signed this document with full knowledge of its significance.

Signature of student: _____ Date: _____

Signature of parent/guardian: _____ Date: _____
(if student is under the age of 18)

SIGNATURE

By signing this form, you acknowledge that the information above is true, accurate, and complete to the best of your knowledge. The following pages must be completed in cooperation with your healthcare provider and submitted to Northland College Health Services.

Signature of student: _____ Date: _____

Signature of parent/guardian: _____ Date: _____
(if student is under the age of 18)

REMINDER: INCLUDE A COPY OF BOTH SIDES OF INSURANCE CARD

SECTION TWO

TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT

LAST NAME _____ FIRST NAME _____ M.I. _____
 DATE OF BIRTH ____/____/____ VISION (note if corrected) _____
 HEIGHT _____ WEIGHT _____ PULSE _____ BP _____

HEALTH EXAMINATION

PHYSICAL EXAMINATION	NL	ABNL	DESCRIBE ABNORMALITIES
GENERAL			
SKIN			
HEAD/EYES/EARS/NOSE/MOUTH			
NECK AND THYROID			
LUNGS/CHEST			
BREASTS			
HEART			
ABDOMEN			
GENITALIA			
BACK/SPINE			
EXTREMITIES/MUSCULOSKELETAL			
NEUROLOGIC			
EMOTIONAL/PSYCHOLOGICAL			

SICKLE CELL TRAIT VERIFICATION

(NCAA mandate for student athletes. Student (or parent/guardian if under 18) must sign waiver on page two if refusing the test)

DATE OF SICKLE CELL TRAIT TEST _____ RESULTS: (circle one) NEGATIVE POSITIVE
 PHYSICAL ACTIVITY RESTRICTIONS? (circle one) Y N If yes, note restrictions: _____

FUNCTIONAL MEDICAL HISTORY

GENERAL	Y	N	EXPLANATION OF YES ANSWERS
1			Has the patient ever been hospitalized?
2			Has the patient ever had a surgical procedure?
3			Is the patient currently under the care of an MD?
4			Does the patient currently have medical restrictions?
5			Has the patient sustained injuries in the last 3 mo?
6			Is the patient currently under the care of a psychiatrist/psychologist?
MEDICAL: patient ever diagnosed with or experienced ...	Y	N	EXPLANATION OF YES ANSWERS
7			ADD / ADHD
8			Asthma
9			Shortness of breath during or after exercise?
10			Pneumonia
11			Concussion? Number: Last:
12			Loss of consciousness? Number: Last:
13			Lost ability to move an extremity? When?
14			Frequent headaches? Number per week:
15			Migraines? Duration: Frequency:

SECTION TWO CONTINUED

FUNCTIONAL MEDICAL HISTORY CONTINUED

MEDICAL: patient ever diagnosed with or experienced ... (cont)		Y	N	EXPLANATION OF YES ANSWERS
16	Epilepsy/seizures			
17	Diabetes			Type:
18	Hypoglycemia			
19	Hepatitis			
20	Mononucleosis			
21	MRSA or herpes			
22	Hernia			
23	Tooth knocked out			
24	Injury to eye			
25	Wear contacts/glasses			
26	Injury to nose			
27	Born with missing kidney, eye, testicle, lung, or other paired organ			
ORTHOPEDIC: patient ever diagnosed with or experience issues with ...		Y	N	EXPLANATION OF YES ANSWERS
28	Fractures			
29	Head/face			
30	Neck			
31	Burner/stinger/brachial plexus			
32	Shoulder			
33	Elbow			
34	Wrist/hand/finger			
35	Chest/ribs			
36	Back/spine			
37	Hips/pelvis			
38	Knee			
39	Ankle			
40	Feet/toes			
41	Shin splints			
42	Stress fractures			
43	Pins/plates/screws			Location:
44	Orthotics/special equipment/braces			Type:
CARDIOVASCULAR: patient ever diagnosed with or experience ...		Y	N	EXPLANATION OF YES ANSWERS
45	Felt dizzy, fainted, nearly fainted during/after exercise			
46	Tire faster than peers			
47	Racing heart rate, palpitations, skipped beats during/after exercise			
48	Chest pain, tightness, pressure during/after exercise			
49	Heart murmur			Age of diagnosis:
50	Hypertension			
51	Elevated cholesterol			
52	Marfan's Syndrome			

SECTION TWO CONTINUED

FUNCTIONAL MEDICAL HISTORY CONTINUED

CARDIOVASCULAR: patient ever diagnosed with or experience ... (cont)		Y	N	EXPLANATION OF YES ANSWERS
53	Anemia			
54	Sickle Cell trait/disease			Limitations:
55	Heat illness, cramps, exhaustion, stroke			
56	Had an EKG/ECG			Date:
57	Any other cardiovascular disorder not listed			
FAMILY HISTORY		Y	N	EXPLANATION OF YES ANSWERS
58	Has anyone in the patient's immediate family experienced heart disease, hypertrophic cardiomyopathy, Marfan's Syndrome, or any other cardiovascular disorder listed in #45-57?			Relation & Disorder:
59	Has anyone in the patient's family suddenly died prior to age 35? (included but not limited to accidental death, drowning, unexpected car accident, or sudden infant death syndrome)			
BODY COMPOSITION / NUTRITION		Y	N	EXPLANATION OF YES ANSWERS
60	Does the patient have weight concerns?			Current weight: Ideal weight:
61	Has the patient experienced significant weight loss?			Amount lost: Duration:
62	Has the patient experienced significant weight gain?			Amount gained: Duration:
63	Has the patient ever been diagnosed with an eating disorder?			
64	Is the patient currently consuming a special diet?			
65	Is the patient taking any supplements?			
66	Does the patient smoke?			Packs per day: Duration:
67	Does the patient drink alcohol?			Frequency:
REPRODUCTIVE HEALTH		Y	N	EXPLANATION OF YES ANSWERS
68	If applicable, has the patient ever had a menstrual period?			Age of first menses:
69	If applicable, has the patient experienced menstrual irregularity?			
70	Has the patient ever experienced an STD/STI?			
FURTHER DISCUSSION		Y	N	EXPLANATION OF YES ANSWERS
71	Is there any concern that the patient should or would like to discuss with a member of the Northland College Health Services staff?			
72	Is there any concern that the patient should or would like to discuss with a member of the Northland College Athletic Training staff?			
73	Is there any concern that the patient should or would like to discuss with a member of the Northland College Counseling Services staff?			
74	Does the patient have any health concern that should prevent them from participating in Northland College Intercollegiate Athletics?			

Northland College requests the attending Health Care Provider to facilitate release of records directly related to any abnormal findings or limitations in activity identified in the course of this examination to Northland College Health Services and Athletic Training Staff. This person has been accepted as a student at Northland College. The information disclosed above will not affect his/her status as a student and will only be used by Northland College Health Services, Northland College Athletic Training staff, and collaborating physicians as a background for providing health care and making recommendations to college-sponsored trip leaders or coaches. No part of this record will be disclosed or released without written client permission, except in cases of medical emergency.

EXAMINER NAME AND TITLE _____

EXAMINER SIGNATURE _____ DATE ____/____/____

EXAMINER ADDRESS _____

EXAMINER PHONE (____) _____ - _____

EXAMINER SIGNATURE