Dear New Student,

We would like to take this opportunity to introduce you to the Chesley Health and Wellness Center at Illinois College. We are located on the third floor of the Bruner Fitness and Recreation Center. Our philosophy is based on the “wellness” of the whole person. Our goal is to support you during your academic, social and spiritual education while at college. This is your Health Care Certificate. The information that you provide on this form will help us care for you while you are a student at Illinois College. If you have questions about the form, please give us a call at 217.245.3038.

There are two parts to the Required Health Care Form. The first part is the Health History and this form must be completed by you (with your family’s help if needed). The second part is the Physical Exam and Immunization Record which must be completed by your health care provider. Be sure that the specific dates of your immunizations for communicable diseases (i.e., measles, mumps, rubella and tetanus diphtheria booster) are indicated, as we need this information to be in compliance with state law. Your physical exam should be done within six to nine months of entrance to the College. If you are a college athlete, this physical exam must be current enough to last through your playing season. Athletic physicals expire one year after the date performed. This physical exam form will serve as your pre-participation Sports Physical for all incoming college athletes and must be in Health Services before your preseason camp begins. Please use the enclosed form.

Completion of all items will expedite your progress through new student orientation. Failure to provide the completed Health Care Certificate by the 10th day of classes will result in a medical hold placement on your student account. New students will not be able to register for the following semester and will not be able to view mid-term or final grades if these forms are not completed. Please mail both completed forms in the enclosed envelope by July 1 if you are enrolling for the fall semester and December 1 if you are enrolling for the spring semester.

Your wellness is our primary concern.

Tami Wright, RN, BSN
Clinical Liaison

Renee Overton
Health Services Coordinator
Please complete this Health Care Certificate and return it to the Chesley Health and Wellness Center before July 1 for fall semester or December 1 for spring semester. Permission to register is dependent upon completion of this form. Please call 217.245.3038 if you have questions.

CHESLEY HEALTH AND WELLNESS CENTER
1101 WEST COLLEGE AVENUE, JACKSONVILLE, IL 62650

STUDENT INFORMATION
Student’s Name ____________________________ Preferred Name________________________ Entry Term (Semester/Year) _____
Street Address __________________________________________
City ____________________________ State __________ Zip __________
Home Phone ____________________________ Student Cell ____________________________
Date of Birth ____________________________ Social Security Number ____________________________
Sex:  ☐ Male  ☐ Female  ☐ Transgender

Person to notify in case of medical emergency:
Name ____________________________ Relationship ____________________________
Address __________________________________________
Home Phone ____________________________ Cell ____________________________ Work ____________________________
If the above number cannot be reached, notify ____________________________ Relationship ____________________________
Home Phone ____________________________ Cell ____________________________ Work ____________________________

Person to notify in case of mental health emergency:  ☐ Same as medical emergency contact  ☐ I do not want to designate at this time
Name ____________________________ Relationship ____________________________
Address __________________________________________
Home Phone ____________________________ Cell ____________________________ Work ____________________________

INSURANCE INFORMATION – Please include a copy of your insurance card (front and back).
In case of treatment as an outpatient at the hospital or should inpatient hospitalization be required, the bill for care will be sent directly to the student, parent or legal guardian unless the name and policy number of insurance coverage is provided. If your son/daughter is covered by such a policy, please fill in the following and attach a front and back copy of the card:
Name of Insured ____________________________________________ Social Security Number ____________________________
Insurance Company ____________________________________________ Group Number ____________________________
ID Number ____________________________________________ Phone ____________________________

CONSENT FOR TREATMENT OF MINOR STUDENTS
Any person who has reached the age of 18 may, in the State of Illinois, sign his or her own consent for treatment at a hospital or other medical care facility. This is also the case for consenting for counseling and other mental health services. If the student has not reached the age of 18, the following must be signed by the student’s parent/guardian for the student to receive treatment.

I, ____________________________ hereby give permission for emergency medical treatment for
______________________________ should it be necessary before s/he reaches the age of 18.

I, ____________________________ hereby give permission for mental health treatment for
______________________________ should it be necessary before s/he reaches the age of 18.
This is the Health Care Provider Form.

Please give this form to your physician, nurse practitioner or physician’s assistant. This form will also serve as a pre-participation Sports Physical for incoming college athletes.

**PROVIDERS**
Please fill out and return to:

Illinois College
Chesley Health & Wellness Center
1101 West College Avenue
Jacksonville, IL 62650

Should you have any questions, contact us at 217.245.3038.
TO THE EXAMINING PROVIDER: Please complete the Physical Exam and Immunization Record. This information is necessary in order that the College may best serve the student. *The NCAA mandates that all student athletes have knowledge of their sickle cell trait status before any participation in intercollegiate sports.

Student's Name ___________________________ DOB_____________ Male  Female  Transgender

Measurements:

Temp _____ Pulse _____ Resp _____ BP _____ Height _____ cms/inches Weight _____ kgs/lbs BMI _____

Urinalysis: Glucose _____ Ketone _____ S.G. _____ Blood _____ pH _____ Protein _____ Nitrates _____ Leukocytes _____

Hgb _____ or Hct _____ % (for menstruating females) Sickle Cell Trait  Yes  No (attach documentation)

Visual Acuity: Uncorrected [ ] Right 20/ ____ Left 20/ ____ Corrected [ ] Right 20/ ____ Left 20/ ____

Are there any abnormalities of the following systems? Please describe fully. Use additional sheet if needed.

<table>
<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Abnormal</th>
<th>Not Examined</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Appearance:</strong></td>
<td></td>
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<tr>
<td>Marfan stigmata, LOC, nutrition, development, mobility, affect, speech, hygiene</td>
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<tr>
<td><strong>Skin:</strong></td>
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<tr>
<td>rash, HSV, lesions suggestive of MRSA, color, tinea corporis, acne</td>
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<tr>
<td><strong>Head:</strong></td>
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<tr>
<td>shape, size, symmetry, scalp, TMJ, lesions, hair</td>
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<td><strong>Eyes:</strong></td>
<td></td>
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<tr>
<td>Lids, conjunctiva, sclera</td>
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<tr>
<td>Extraocular muscles</td>
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<tr>
<td>Visual fields</td>
<td></td>
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<tr>
<td>Pupils: size, reaction to light and accommodation</td>
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<td><strong>Fundi</strong></td>
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<tr>
<td><strong>Ears:</strong></td>
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<tr>
<td>pinna, canals, TMs, hearing</td>
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<td><strong>Nose:</strong></td>
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<tr>
<td>patency, nares, sinuses, nasal mucosa, septum, turbinates</td>
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<td><strong>Mouth:</strong></td>
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<td>lips, gums, teeth, mucosa, palate, tongue</td>
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<tr>
<td>Section</td>
<td>Examination Details</td>
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<tr>
<td>Throat:</td>
<td>pharynx, tonsils, uvula</td>
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<tr>
<td>Neck:</td>
<td>ROM, symmetry, palpation, thyroid, lymph nodes</td>
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<tr>
<td>Breasts:</td>
<td>size, symmetry, skin, nipples, palpation, nodes</td>
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<tr>
<td>Chest/Lung:</td>
<td>excursion, palpation, percussion, auscultation</td>
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<tr>
<td>Cardiac:</td>
<td>PMI, palpation, rate, rhythm, S1, S2, murmurs (standing, supine, +/- Valsalva),</td>
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<tr>
<td></td>
<td>gallops, bruits, extra sounds</td>
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<tr>
<td>Abdomen:</td>
<td>appearance, bowel sounds, bruits, percussion, palpation, liver, spleen, flank,</td>
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<tr>
<td></td>
<td>suprapubic, hernia</td>
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<tr>
<td>Anorectal:</td>
<td>perianal, digital rectal, stool guaiac</td>
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<tr>
<td>Female Genitalia:</td>
<td>Internal: vaginal mucosal, cervix</td>
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<td></td>
<td>Bimanual: vagina, cervix, uterus, adnexa</td>
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<tr>
<td>Male Genitalia:</td>
<td>penis, scrotum, testes, hernia</td>
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<tr>
<td>Lymph Nodes:</td>
<td>cervical, subclavian, axillary, inguinal, other</td>
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<tr>
<td>Musculoskeletal:</td>
<td>Back/Spine: ROM, palpation</td>
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<tr>
<td>Upper Extremity:</td>
<td>ROM, strength, palpation of shoulder/arm/elbow/forearm/wrist/hand/fingers</td>
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<tr>
<td>Lower Extremity: ROM, strength, palpation of hip/thigh/knee/leg/ankle/foot/ toes</td>
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<tr>
<td>Functional: Duck-walk, single leg hop</td>
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<tr>
<td>Peripheral Vascular: Upper Extremity: pulses, appearance, temp</td>
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<tr>
<td>Lower Extremity: pulses, appearance, temp, simultaneous femoral and radial pulses</td>
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<tr>
<td>Neurologic: cranial nerves, motor, sensory, cerebellar, reflexes, gait, mental status</td>
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</tbody>
</table>

**ASSESSMENT:**

**PLAN:**

**Handouts:**
- [ ] SBE
- [ ] STE
- [ ] Nutrition
- [ ] Other ________________

**Recommendations:**
- [ ] Dental
- [ ] Eye Exam
- [ ] Gyne Exam
- [ ] Other ________________

**Ordered:**
- [ ] CBC
- [ ] UA
- [ ] CMP/BMP
- [ ] Sickle Cell
- [ ] Glu
- [ ] CHOL/HDL
- [ ] CXR
- [ ] PPD
- [ ] IGRA
- [ ] Other ________________

**Immunizations:**
- [ ] MMR
- [ ] Td/Tdap
- [ ] IPV
- [ ] Varicella
- [ ] Meningococcal
- [ ] HPV
- [ ] Hepatitis A
- [ ] Hepatitis B

Is student receiving treatment from physician currently? [ ] Yes  [ ] No
If yes, please specify: ____________________________________________

Is there loss/seriously impaired function of any paired organ? ____________________________________________

Does this student have special dietary requirements? [ ] Yes  [ ] No
If yes, please specify: ____________________________________________
On the basis of this examination, I approve the student’s participation in:

- Any intercollegiate sports for one year  Yes  No  Limited
- Any physical education activity class with no restrictions
- An adapted physical education program to exclude the following activities:
- No physical education activity classes for the following reason(s):

**TUBERCULOSIS (TB) SCREENING/TESTING**

Please answer the following questions:

- Have you ever had a positive TB skin test?  Yes  No
- Have you ever been vaccinated with BCG?  Yes  No
- Have you ever had close contact with persons known or suspected to have active TB disease?  Yes  No
- Were you born in one of the countries or territories listed below that have a high incidence of active TB disease?  Yes  No
  (If yes, please CIRCLE the country, below)

Afghanistan  Comoros  Indonesia  Myanmar  Sierra Leone
Algeria  Congo  Iran (Islamic Republic of)  Namibia  Singapore
Angola  Côte d’Ivoire  Iraq  Nauru  Solomon Islands
Anguilla  Democratic People’s Republic of Korea  Kazakhstan  Nepal  Somalia South Africa
Argentina  Democratic Republic of the Congo  Kenya  Nicaragua  South Sudan
Armenia  Djibouti  Kiribati  Niger  Sri Lanka
Azerbaijan  Dominican Republic  Kuwait  Nigeria  Sudan
Bangladesh  Ecuador  Kyrgyzstan  Northern Mariana Islands  Suriname
Belarus  El Salvador  Lao People’s Democratic Republic  Panama  Swaziland
Belize  Equatorial Guinea  Latvia  Paraguay  Tajikistan
Benin  Eritrea  Lesotho  Peru  Thailand
Bhutan  Estonia  Liberia  Philippines  Timor-Leste
Bolivia (Plurinational State of)  Ethiopia  Libya  Poland  Togo
Botswana  Equatorial Guinea  Lithuania  Portugal  Trinidad and Tobago
Brazil  Eritrea  Madagascar  Qatar  Tunisia
Brunei Darussalam  Ethiopia  Malawi  Republic of Korea  Turkmenistan
Bulgaria  Fiji  Malaysia  Republic of Moldova  Vanuatu
Burkina Faso  French Polynesia  Maldives  Romania  Venezuela (Bolivarian Republic of)
Burundi  Gabon  Mali  Russian Federation  Viet Nam
Cabo Verde  Gambia  Marshall Islands  Rwanda  Yemen
Cambodia  Georgia  Mauritania  Saint Vincent and the Grenadines  Zambia
Cameroon  Ghana  Mauritius  Senegal  Zimbabwe
Central African Republic  Greenland  Mexico  Seychelles  China
Chad  Guam  Micronesia (Federated States of)  São Tomé and Príncipe  Colombia
China  Guatemala  Mongolia  Senegal  China, Hong Kong SAR  Guinea  Montenegro  Senegal
China, Macao SAR  Guinea-Bissau  Morocco  Senegal  Colombia
Comoros  Guyana  Mozambique  Senegal  India
Democratic People’s Republic of Korea  Haiti  Seychelles  Somalia South Africa
Democratic Republic of the Congo  Honduras  South Sudan  South Sudan
Djibouti  Indonesia  Sudan  Sri Lanka
Ecuador  Iran (Islamic Republic of)  Suriname  Sudan
El Salvador  Iraq  Swaziland  Togo
Equatorial Guinea  Kazakhstan  Tajikistan  Tonga
Eritrea  Kenya  Thailand  Tuvalu
Ethiopia  Kiribati  Timor-Leste  Ukraine
Estonia  Kuwait  Trinidad and Tobago  United Arab Emirates
Gabon  Kyrgyzstan  Tunisia  United Republic of Tanzania
Gambia  Lao People’s Democratic Republic  Turkmenistan  Uruguay
Georgia  Latvia  Vanuatu  Uzbekistan
Ghana  Lesotho  Venezuela (Bolivarian Republic of)
Greenland  Liberia  Viet Nam  Yemen
Guam  Libya  Yemen
Guatemala  Lithuania  Zambia  Zimbabwe
Guinea  Madagascar  Zimbabwe
Guinea-Bissau  Malawi  China
Guyana  Maldives  China, Macao SAR
Haiti  Mali  China, Hong Kong SAR
Honduras  Marshall Islands  China, Macao SAR
India  Mauritania  Radom
Have you had frequent or prolonged visits* to one or more of the countries or territories listed on the previous page with a high prevalence of TB disease? (If yes, CHECK the countries or territories, on the previous page)

- Yes
- No

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?

- Yes
- No

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease?

- Yes
- No

Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol?

- Yes
- No

If the answer is YES to any of the above questions, Illinois College requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester.

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.

Tuberculin Skin Test
- Date given: ____/____/____
- Date read: ____/____/____
- Result: __________ (record actual mm of induration, transverse diameter; if no induration, write “0”)
- Interpretation (based on mm of induration as well as risk factors):
- Positive
- Negative

Interferon Gamma Release Assay (IGRA)
- Date Obtained: ____/____/____
- Specifying method: QFT-GIT
- T-Spot
- Other
- Result:
- Negative
- Positive
- Indeterminate
- Borderline (T-Spot only)

Chest X-ray (required if TST or IGRA or T-Spot is positive)
- Result:
- Normal
- Abnormal
- Date of chest x-ray: ____/____/____

**IMMUNIZATION RECORD (All dates must have month, day and year)**

As of July 1989, all students born after January 1, 1957 registering for the first time at public or private colleges in Illinois must present evidence of immunity against the vaccine-preventable diseases. **If no proof of immunization, certification of medical exemption, or statement of religious objection is presented, the student will not be permitted to register for courses** (Public Act 85-1315). Form recommended by ACHA’s Vaccine-Preventable Disease Task Force. *Required for entrance.

**REQUIRED IMMUNIZATIONS:**

**A. MMR* (MEASLES, MUMPS, RUBELLA)**

(Two doses required at least 28 days apart for students born after 1956 and all health care professional students.)

- Dose 1 given at age 12 months or later   #1 ___/__/____
- Dose 2 given at least 28 days after first dose   #2 ___/__/____

**B. MENINGOCOCCAL QUADRIVALENT**

(Illinois Law: Students must have had one menactra (conjugate) after age of 16.)

(A, C, Y, W-135) One or 2 doses for all college students; revaccinate every 5 years if increased risk continues.

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).
   a. Dose #1 ___/__/____
   b. Dose #2 ___/__/____
2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available). Date: ___/__/____
C. TETANUS, DIPHTHERIA, PERTUSSIS*
(Illinois Law: Students must have had a TDAP within the last 10 years)
1. Primary series completed?  Yes  No
   Date of last dose in series: ___/___/
2. Date of most recent booster dose: ___/___/
   Type of booster:  Td  Tdap  Tdap booster recommended for ages 11-64 unless contraindicated

D. Polio*
Primary series, doses at least 28 days apart. Three primary series are acceptable. See ACIP website for details.
1. OPV alone (oral Sabin three doses):
   a. Dose #1 ___/___
   b. Dose #2 ___/___
   c. Dose #3 ___/___
2. IPV/OPV sequential:
   IPV #1 ___/___
   IPV #2 ___/___
   OPV #3 ___/___
   OPV #4 ___/___
3. IPV alone (injected Salk four doses):
   a. Dose #1 ___/___
   b. Dose #2 ___/___
   c. Dose #3 ___/___
   d. Dose #4 ___/___

STRONGLY RECOMMENDED IMMUNIZATIONS:
E. HEPATITIS B
(All college and health care professional students. Three doses of vaccine or two doses of adult vaccine in adolescents 11–15 years of age, or a positive hepatitis B surface antibody meets the requirement.)
1. Immunization (Hepatitis B)
   a. Dose #1 ___/___  Adult formulation or ___Child formulation
   b. Dose #2 ___/___  Adult formulation or ___Child formulation
   c. Dose #3 ___/___  Adult formulation or ___Child formulation
2. Immunization (Combined Hepatitis A and B vaccine)
   a. Dose #1 ___/___
   b. Dose #2 ___/___
   c. Dose #3 ___/___
3. Hepatitis B surface antibody  Date: ___/___  Result:  Reactive  Non-reactive

F. INFLUENZA
   Trivalent (IIV3)  Quadrivalent (IIV4)  Recombinant (RIV3)  Live attenuated influenza vaccine (LAIV)
Date of last dose: ___/___/

G. VARICELLA
(Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets the requirement.)
1. History of disease:  Yes  No  or  Birth in U.S. before 1980:  Yes  No
2. Varicella antibody: ___/___/___  Result:  Reactive  Non-reactive
3. Immunization:  Dose #1 ___/___
   Dose #2 given at least 12 weeks after first dose ages 1–12 years and at least 4 weeks after first dose if age 13 years or older ___/___/___
H. HUMAN PAPILLOMAVIRUS VACCINE (HPV2/HPV4/HPV9)
(Three doses of vaccine for females and males 11–26 years of age at 0, 1–2, and 6 month intervals.)
Immunization (indicate which preparation, if known)
☐ Quadrivalent (HPV4) ☐ Bivalent (HPV2) ☐ 9-valent (HPV9)
a. Dose #1__/__/__
b. Dose #2__/__/__
c. Dose #3__/__/__

I. HEPATITIS A
1. Immunization (Hepatitis A):
   a. Dose #1__/__/__
   b. Dose #2__/__/__
2. Immunization (Combined Hepatitis A and B vaccine):
   a. Dose #1__/__/__
   b. Dose #2__/__/__
   c. Dose #3__/__/__

J. PNEUMOCOCCAL POLYSACCHARIDE VACCINE
☐ PCV 13  Date__/__/__  ☐ PPSV 23  Date__/__/__

K. MENINGOCOCCAL SEROUGROUP B
(Two or three dose series; may be given to any college student or for outbreak control; may be given with quadrivalent meningococcal vaccine at different anatomic site. Must complete series with the same vaccine.)
1. MenB-RC (Bexsero)  ☐ routine  ☐ outbreak –related
   a. Dose #1__/__/__
   b. Dose #2__/__/__
   OR
1. MenB-FHbp (Trumenba)  ☐ routine  ☐ outbreak –related
   a. Dose #1__/__/__
   b. Dose #2__/__/__

HEALTH CARE PROVIDER CERTIFICATION
Health Care Provider (please print) ____________________________________________
Health Care Provider’s Signature ____________________________________________ Date ______________________
Address _______________________________________________________________________
Telephone __________________________ Fax ________________________________
HEALTH HISTORY

1. Do you have any allergies?  □ Yes  □ No  □ Other: ____________________________
   □ Medicines ____________________ □ Pollens ____________________ □ Food ____________ □ Stinging Insects ____________
   □ Animals ____________________ □ Other: ____________________________

2. If yes, are you receiving allergy shots?  □ Yes  □ No
   If yes, will the shots continue while attending college?  □ Yes  □ No

3. Give details and dates of all operations and/or hospitalizations (including tonsils and adenoids).  □ None

4. Give details of accidents including dislocations, fractures and any injury with loss of consciousness.  □ None

5. Are you taking any prescription and/or nonprescription medications or supplements (herbal and nutritional)?  □ Yes  □ No
   If yes, please list all prescription and non-prescription medications (name, dosage, and frequency):

6. When was your last dental examination? ____________________________
   When was your last eye examination? ____________________________

7. Do you wear glasses/contact lenses?  □ Yes  □ No

8. Have you been under the care of a medical specialist during the past year?  □ Yes  □ No
   If yes, indicate the reason: ____________________________
   Name, address and phone of specialist ____________________________
   Dates of Treatment ____________________________

9. Have you been under the care of a Mental Health specialist (counselor, psychologist, social worker, psychiatrist) during the past year?  □ Yes  □ No
   If yes, indicate the reason: ____________________________
   Name, address and phone of specialist ____________________________
   Dates of Treatment ____________________________

10. Give age or ages at which you have had any of the following:
   □ Anxiety Disorder ______  □ Hearing Loss ______  □ Skin Disorders ______
    □ Asthma ______  □ Heart Disease/Murmur/Palpitation ______  □ Strep Throat ______
    □ Bipolar Disorder ______  □ Hepatitis A, B or C ______  □ Stomach Ulcer ______
    □ Cancer ______  □ Infectious Mononucleosis ______  □ Substance Abuse ______
    □ Chicken Pox ______  □ Malaria ______  □ Alcohol ______
    □ Colitis ______  □ Measles ______  □ Tobacco ______
    □ Depression ______  □ Mumps ______  □ Other Drugs ______
    □ Diabetes ______  □ Pneumonia ______  □ Suicide Attempt ______
    □ Digestive Tract Problem ______  □ Post Traumatic Stress Disorder ______  □ Thyroid Disease ______
    □ Eating Disorder ______  □ Rheumatic Fever ______  □ Tuberculosis ______
    □ Epilepsy/Seizures ______  □ Rheumatism ______  □ Urinary Tract Infection ______
    □ German Measles ______  □ Hay Fever ______  □ Sickle Cell Trait/Disease ______
    □ Other diseases (name) ____________________________
11. Any family history of medically unexplained or cardiac cause of death under age 50?  □ Yes  □ No
   If yes, please explain: ____________________________

12. Do you have pain or other trouble with your back, legs, feet, hands or joints?  □ Yes  □ No
   If yes, please explain: ____________________________

13. Has your weight changed in the past six months?  □ Yes  □ No
   Gain or loss? __________________  How much? ________  Why? ____________________________

   Do you have any concerns about food?  □ Yes  □ No
   If yes, please explain: ____________________________

CERTIFICATION OF INFORMATION
I certify that the information provided is accurate to the best of my knowledge.

Student Signature ____________________________ Date ____________________________

Parent Signature ____________________________ Date ____________________________