CONFIDENTIAL

Medical History Report

*Due **August 1** for students entering fall semester. Due **January 1** for students entering spring semester. Required by all resident students and students in sports activities. Physical needs to be completed after **March 1**.*

PLEASE PRINT

Date (present) _______________ Date of entrance _______________ Major ____

❑ Resident *(on-campus housing)* ❑ Commuter Social Security number ________ - ________ - ___________ Date of birth ____ / ____ / _______________

Last name ____ First name ____________________________ MI ____ ❑ Female ❑ Male

Home address ____ City ______________________________ State ____ Zip _________

Are you a veteran? ❑ Yes ❑ No Marital status: ❑ Single ❑ Married

Are you planning on participating in an intercollegiate sport? ❑ Yes ❑ No

Emergency contact: Name ____ Relationship _______________________________

Address ____ Home phone (   ) ______________________________

Business address ____ Work phone (   ) ______________________________

The law requires that parental permission be obtained for procedures on ***minors***. The statement below is prepared for your son's or daughter's protection.

CONSENT FOR TREATMENT

In the event of a medical or surgical need for the undersigned student while at Marian University, I hereby authorize the performance upon said student of such medical or surgical procedures as may be prescribed by a physician licensed to practice medicine and surgery.

Dated this _________________________ day of____20 _____________

Student signature ____

Parent or Guardian (if student is under age 18)

Name (please print) ____

Signature ____

Street ____

City/State/Zip____

WITHOUT SIGNED CONSENT FOR TREATMENT, NO STUDENT WILL BE TREATED AT THE STUDENT HEALTH SERVICES CENTER UNLESS AN EMERGENCY ARISES!

A situation rarely arises in which emergency treatment or hospitalization is necessary but if an emergency should occur, prompt action may be imperative. We make an attempt to communicate with some member of a student's family when hospitalization is required, but we are sometimes expressly requested by a physician to obtain authority for treatment when it is impossible to contact the parents. The consent set forth below may be helpful in such a situation.

INSURANCE DATA

I carry hospitalization and/or illness and accident insurance. ❑ Yes ❑ No

The name of the insurance company is ____

The group and certificate numbers are ____

(If changes in the carrier are made, the student must have updated cards and information.)

Please provide a copy of your insurance card or information. Attach copy of BOTH sides of card.

If you have any questions, contact: Office of Student Engagement 920.923.7666 **OR** Office of Student Health Services 920.923.7615.

Please return this form to:

Marian University — Office of Student Engagement
45 South National Avenue I Fond du Lac, WI 54935-4699 I Fax: 920.926.2103

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PRE-PARTICIPATION PHYSICAL EVALUATION

Physical Examination Form

MARIAN UNIVERSITY
Sports Medicine Department

Name ______________________________ Date of birth ________________

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight ❑ Male ❑ Female BP / (/) Pulse Vision R 20/ L 20/ Corrected ❑ Y ❑ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance — Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses — Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)**		
Skin — HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic***		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional — Duck-walk, single leg hop		

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. **Consider GU exam if in private setting. Having third party present is recommended.
***Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

❑ Cleared for all sports without restriction

❑ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ____________________

❑ Not cleared

  ❑ Pending further evaluation ❑ For any sports

  ❑ For certain sports ____________________

  Reason ____________________

Recommendations ____________________

____

____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ____________________ Date ____________

Address____________________Phone____________

Signature of physician ____________________, MD or DO

PRE-PARTICIPATION PHYSICAL EVALUATION

History Form

NOTE: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.

MARIAN UNIVERSITY
Sports Medicine Department

Date of Exam ____________ Name ____ Date of birth ____________

Sex ______ Age _____ Grade _____ School ___________________________ Sport(s) ______________________________

MEDICINES AND ALLERGIES Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:

____

____

____

Do you have any allergies? ❑ Yes ❑ No If yes, please identify specific allergy:

❑ Medicines ____________________ ❑ Pollens ________________ ❑ Food ____________________ ❑ Stinging Insects ____________

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify: ❑ Asthma ❑ Anemia ❑ Diabetes ❑ Infections ❑ Other: ______		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ❑ High blood pressure ❑ Heart murmur ❑ High cholesterol ❑ Heart infection ❑ Kawasaki disease ❑ Other: ______________________		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here____

____

____

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ____

Signature of parent/guardian_______________________________________

Date______________________

PRE-PARTICIPATION PHYSICAL EVALUATION

Clearance Form

MARIAN UNIVERSITY
Sports Medicine Department

Name ________________________________ Sex: ❑ M ❑ F Age ______ Date of birth _____ / _____ / ________

❑ Cleared for all sports without restriction

❑ Cleared for all sports without restriction with recommendations for further evaluation or treatment for__________________________

____

❑ Not cleared
- ❑ Pending further evaluation
- ❑ For any sports
- ❑ For certain sports ____
- Reason ____

Recommendations ____

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I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ________________________________ Date _______________

Address ________________________________ Phone ________________________

Signature of physician ________________________________, MD or DO

EMERGENCY INFORMATION

Allergies ____

____

____

____

____

Other information ____

____

____

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VACCINE DECLINATION STATEMENT

I understand that due to my living on campus at Marian University I may be at risk of acquiring an infection from being unvaccinated. I have been given the opportunity to be vaccinated at my own expense. However, I decline the vaccinations and I am at risk of acquiring the disease. If I should acquire a disease I would be furloughed from school at my own expense.

Vaccines which I am declining: ❑ MMR ❑ TDAP/TD ❑ HPV ❑ Meningococcal conjugate ❑ Varicella ❑ Hep A ❑ Hep B

Reason for exemption ____

Signature ________________________________ Date ________________________