Semester _____ Fall _____Spring _____ Year _____

Vincennes University

Allergies _____

Complete _____
Inc. _____
PPD or CXR _____
MW or MV _____
Hep B _____
FOR OFFICE USE ONLY

REPORT OF MEDICAL HISTORY

COMPLETE PAGE 1 BEFORE GOING TO YOUR PHYSICIAN FOR EXAMINATION.
CHILD CARE STUDENTS MUST RETURN THE COMPLETED FORM BEFORE CLASSES BEGIN

☐ Male
☐ Female

Major _____

NAME: Last (Print) First Middle (Maiden) DATE OF BIRTH

HOME ADDRESS: Number and Street City State Zip Code

HOME TELEPHONE NUMBER BUSINESS TELEPHONE NUMBER

PARENTS NAME ADDRESS TELEPHONE NUMBER

PERSONAL HISTORY

PLEASE ANSWER ALL QUESTIONS. Comment on all positive answers. USE CHECK MARK (✔)

HAVE YOU HAD?	Yes	No
Scarlet Fever		
Measles (Rubeola)		
German Measles (Rubella)		
Mumps		
Mononucleosis		
Chicken Pox		
Malaria		
Tuberculosis		
Poliomyelitis		
Rheumatic Fever		
Epilepsy		

List all Medication you are now taking:

	Yes	No
FEMALES ONLY		
Menstrual Cramps		
Excessive Flow		
Hard Breast Lump		
Pregnancy		

	Yes	No
Diabetes		
Recurrent Headache		
Insomnia		
Frequent Anxiety		
Recent Gain or Loss of Weight		
Pain? Pressure in Chest		
Chronic Cough		
Palpitations (Heart)		
Heart Murmur		
Shortness of Breath		
Recurrent Diarrhea Gallbladder Trouble		
or Gallstones		
Jaundice		
Stomach or Intestinal Problems		
Back Problems		
Frequent Urination/Recurrent Urinary Tract Infections		
Rupture, Hernia		
Disease or Injury to Bones or Joints		
Blood Disorders		
Surgery (Please Describe)		

NAME: _____ BANNER ID

COMMENTS/ADDITIONAL INFORMATION

_____

_____

_____

Approval

By signing below, I acknowledge that I have reviewed the information on meningococcal meningitis.

Student Signature _____ Parent or Guardian Signature _____ Date _____
(If under age 18)

(Please keep a copy of entire form for your records.)

REPORT OF PHYSICAL EXAMINATION

Physician: (A) Please review the student's Report of Medical History (Page 1), comment on all positive answers. (B) Administer a physical examination, complete this page, sign, then RETURN TO VINCENNES UNIVERSITY IMMUNIZATION. The health information and physical exam must be done within last 12 months, and is required for all health occupations and child care majors. The health information provided will be used as history for purposes of treatment and/or ongoing health care.

_____ Mr.
_____ Mrs.
_____ Miss

LAST NAME (Print) FIRST NAME MIDDLE NAME (MAIDEN)

The "College Immunization Law" (IC20-12-71) requires immuniations as specified below for all matriculating students.

REQUIRED IMMUNIZATIONS

(You must fulfill these requirements prior to the first day of classes)

MMR Vaccination

Must have two dates

vaccine 1 ____/____/____ Month Day Year

vaccine 2 ____/____/____ Month Day Year

- or-

Measles (Rubeola) Immunity - Must have 2 doses live measles vaccine.

vaccine 1 ____/____/____ Month Day Year

vaccine 2 ____/____/____ Month Day Year

Both doses must be given after 1967 **AND** the first on or after the first birthday and the doses must be separated by at least 30 days.

or

Date of **physician-diagnosed** measles disease ____/____/____ Month Day Year

or

Has an immune titer (specify date of test) ____/____/____ Month Day Year

or

Born before January 1, 1957 - vaccine not required

Rubella (German Measles) Immunity - Must have one dose:

(Vaccine must be on or after first birthday). ____/____/____ Month Day Year

or

Has an immune titer (specify date of test) ____/____/____ Month Day Year

Born before January 1, 1957 - vaccine not required _____ Yes

Mumps Immunity - Must have one of the following: Immunized with vaccine

(must be on or after first birthday) ____/____/____ Month Day Year

or

Date of physician-diagnosed mumps disease ____/____/____ Month Day Year

or

Has an immune titer (specify date of test) ____/____/____ Month Day Year

or

Born before January 1, 1957 - vaccine not required _____Yes

PLEASE CIRCLE ONE: given within the last 10 years

T/d or Tdap ____/____/____ Month Day Year

RECOMMENDED IMMUNIZATION

Hepatitis-B (Series or waiver required for Health Occupations majors).

Dose 1 ____/____/____ Month Day Year

Dose 2 ____/____/____ Month Day Year

Dose 3 ____/____/____ Month Day Year

Meningococcal Vaccine ____/____/____ Month Day Year

PPD (mantoux within the past 6 months (tine or monovac not acceptable)

Date Given _____Date Read _____

Results _____(mm induration)

CXR required if applicable: Date of CXR _____ Results _____

Age _____Height _____ Weight _____

Uncorrected Vision: Far R 20/_____L 20/ _____ Near R _____L ____

Corrected Vision: Far R 20/_____L 20/ _____ Near R _____L ____

Contact Lenses ___ Yes ___ No Blood Pressure _____Pulse_____

Are there any abnormalities of the following system? Describe fully below	Yes	No
Head		
Eyes (Other than Acuity)		
Ears		
Nose		
Throat		
Respiratory		
Cardiovascular/Hematological		
Gastrointestinal		
Dental		
Genitourinary		
Hernia		
Musculoskeletal		
Metabolic/Endocrine: Anomaly History		
Neuropsychiatric		
Skin		
Is there loss or seriously impaired function of any paired organs?		
Is the patient now under treatment for: (a) Serious medical condition?		
(b) Serious emotional condition?		
Do you have any recommendation regarding the care of this student?		
Are you the patient's regular physician?		

Recommendations for physical activity:
(Physical Education, Intramurals and Varsity Sports)
Unlimited _____ Limited _____ Explain:

Medical Contraindication Statement:

Immunization Contraindication:

_____ none _____ yes

If yes, give reasons _____

_____

_____

PHYSICIAN'S SIGNATURE _____

ADDRESS _____

TELEPHONE NUMBER _____ **DATE OF EXAM** _____

PRINT PHYSICIAN LAST NAME _____

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