

Name _____

SIMPSON COLLEGE



Student Health Form

Medical History, Physician's Report, and Immunizations

Please return completed health forms to Student Health Services in the Office of Student Development. All new freshmen and transfers need to complete the emergency contact, medical history, and immunization sections. Please return these sections by August 1.

Athletic Physicals: Student athletes are required to submit proof of a completed physical exam prior to participation in practice/competition. NCAA regulations require that the physical exam be dated within six months of the athlete's first scheduled practice.

Student Health Insurance

- Simpson College requires all full-time students to provide proof of health insurance.
- The proof of insurance requirement is fulfilled by completing an on-line enroll/waiver process. Students will be notified when the site is open for activity. Paper copies of an insurance card **will not** satisfy the insurance requirement.
- Students not completing the on-line process will be enrolled in the Simpson/Aetna Student Health Insurance. The premium will be billed to the student's account.
- All students should have proof of insurance on their person to access medical care if needed.

For further information or questions contact Rita Audlehelm, RN, Director of Student Health Services, 515-961-1604.

For Office Use Only:

Date Received: _____

Student Athlete: Yes No

Copy to Athletic Office (date): _____

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Student Health Records

Student's Name: _____ Social Security No: _____
Last First Middle

Birth date: M _____ D _____ Y _____ Sex: _____ M _____ F _____ International Student: _____ Y, home country: _____ N

Do you plan to participate in any Simpson College intercollegiate sports? _____ Y Sport(s) _____ N

High School Attended: _____

Home Address: _____
Street City State Zip Phone

In case of emergency, please contact:

1. Contact Name: _____ Relationship: _____

Contact Phone: Home _____ Work _____ Cell _____

2. Contact Name: _____ Relationship: _____

Contact Phone: Home _____ Work _____ Cell _____

3. Contact Name: _____ Relationship: _____

Contact Phone: Home _____ Work _____ Cell _____

Medical History - Family

	Birth Year	Occupation	State of Health	Age	Deceased	Have any of your relatives had any of the following?				Yes	No	Relation
						Yes	No	Relation				
Father												
Mother								Arthritis				Heart Disease
Siblings								Asthma, Hay Fever				Kidney Disease
								Cancer				Mental Health Disorder
								Depression				Substance Abuse
								Diabetes				Tuberculosis
								Epilepsy				Other _____

Medical History – Personal Please check if you have, or have concerns about, the following:

Have you had or are you concerned about?	Yes	No		Yes	No		Yes	No		Yes	No
Anxiety			Eye trouble			Measles			Stomach/intestinal trouble		
Asthma			Depression			Measles (German)			Trouble sleeping		
Attention Deficit Disorder			Frequent indigestion			Mononucleosis			Tuberculosis		
Back pain			Gallbladder trouble			Mumps			Urinary tract problems		
Cancer			Gum/tooth trouble			Pneumonia			STD's		
Chemical dependency			Hay Fever			Polio			Weakness, paralysis		
Chest pain/pressure			Head injury			Recent wt. gain/loss					
Chicken pox			Heat Illness			Recurrent colds			Female Students:		
Chronic cough			Heart murmur			Recurrent diarrhea			Irregular periods		
Diabetes			Heart palpitation			Recurrent headaches			Severe cramps		
Dizziness/fainting			High/low blood pressure			Rheumatic fever			Excessive flow		
Ear/nose/throat trouble			Jaundice/Hepatitis			Scarlet fever			Pregnancy		
Eating disorder			Joint injury			Shortness of breath			Other Conditions:		
Seizure disorder			Malaria			Sinusitis					

	Yes	No	Comments
Have you had any illness or injury or surgery which required hospitalization?			
At any time, have any of your activities been restricted due to illness, injury, etc? Please explain if yes.			
Have you ever experienced any personal or emotional difficulties which required professional attention?			If you would like more information about mental health services you may contact Simpson College Counseling Services at 515-961-1556 or visit the web site at www.simpson.edu/counseling/index.html .
Have you had a recent - (give dates for each): Medical exam? Dental exam? Eye exam?			
Please list any medications you currently take:			
Please list any allergies (including medications, food, and environmental):			

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Physician's Report

Physical examinations are required for all athletes, and strongly recommended for non-athletes. **Physical forms for athletes need to be submitted by August 1 to be eligible.**

Examination

Height: _____ Weight _____ Blood Pressure _____ / _____

Vision: L _____ R _____ Glasses Yes _____ No _____

Anisocoria L _____ R _____ Contact Lenses Yes _____ No _____

Eye Protection Yes _____ No _____

Medical Exam

	Normal	Abnormal	Comments
HEENT Fundoscopic Exam			
Ears			
Mouth			
Throat			
Dental			
Thyroid			
Nodes			
Lungs			
Heart/Murmurs			
Abdomen			
Genitalia			
Hernia			
Skin			
Body Fat% (opt)			

Labs: if indicated _____

Urinalysis: Albumin _____ Sugar _____ Sp.Gr. _____

Hematocrit _____ or Hemoglobin _____ TB Test _____ Date Read _____

Musculoskeletal

	Normal	Abnormal		Normal	Abnormal
Neck			Quad/Hamstring		
Shoulder			Ankle/feet		
Elbow			Back/spine		
Hands			Toe/Heel Walk		
Wrist			Duck Walk		
Knees					

Comments: _____

Below Required for Athletes

I herewith certify that _____ has been evaluated in the following areas as indicated below to be physically fit to participate in school interscholastic activities

Medical History Y/N _____ (name) Collision Sports _____ Cleared _____ Not Cleared

Medical Exam Normal/Abnormal _____ (name) Contact Sports _____ Cleared _____ Not Cleared

Musculoskeletal Normal/Abnormal _____ (name) Non Contact Sports _____ Cleared _____ Not Cleared

If not cleared, reason: _____ Modifications or exceptions: _____

→ Attending Physician signature (MD or DO) _____

Print Name _____ Date _____

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Immunization History

Immunizations should be current; please fill in the dates below. Consult your physician with any questions concerning vaccinations.

MMR combo (measles, mumps, rubella)
Dose #1 (15 months old or after) _____
Dose #2 (5 years old or after) _____

IF given as separate doses, please list:

Measles
Dose #1 _____
Dose #2 _____

Mumps
Dose #1 _____

Rubella
Dose #1 _____

Polio
Primary series completed _____

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)

History of the disease: _____ Yes _____ No
Birth in the U.S. prior to 1980: _____ Yes _____ No
Varicella antibody: date _____
Result: _____ Reactive _____ Non-reactive
Immunization:
Dose #1 _____
Dose #2 _____

Tetanus/Diphtheria/Pertussis
Primary Series Completed _____
Booster (within past 10 years) _____

Hepatitis B Series (recommended) _____
Dose #1 _____
Dose #2 _____
Dose #3 _____

Tuberculosis Screening
International students are required to complete the Tuberculosis Screening Questionnaire found at www.simpson.edu/health
Date Given _____
Date Read _____ Results: _____

Hepatitis A
Dose #1 _____
Dose #2 _____

Meningitis (recommended) _____

Meningitis Information Statement:
TO BE SIGNED BY STUDENT, OR PARENT OR LEGAL GUARDIAN IF STUDENT IS A MINOR, AND ALSO BY THE STUDENT REGARDLESS OF AGE.

My signature below indicates that I have read the attached information regarding meningitis and its risks to college students. I am aware that a vaccine is available for meningitis and of the benefits of this vaccine.

_____ Date _____
→ Student Signature

_____ Date _____
→ Parent Signature

ALL Students need to read and sign below:

I hereby state that the information on this health form is true and give permission for the Student Health Services to release information to the Office of Student Development and to health care providers and facilities who are included in my treatment.

→ Student Signature _____ Date _____

→ Parent Signature (required if student is under 21) _____ Date _____

STUDENT ATHLETES ONLY need to read and sign below:

I do not know of any existing physical condition or additional health reason that would preclude participation in sports. I certify that the answers to the above questions are true and accurate. I approve participation in athletic activities. I hereby authorize release to the school nurse and/or athletic medical staff of the information contained in this document. Upon written request, I may receive a copy of this document for my personal health care provider or athletic medical staff.

→ Student Signature _____ Date _____

→ Parent Signature (required if student is under 21) _____ Date _____