CARDINAL STRITCH UNIVERSITY

CONFIDENTIAL REPORT OF MEDICAL HISTORY

ALL FULL TIME STUDENTS MUST COMPLETE THIS FORM

Today's Date_____ **Anticipated Date of Entrance**_____ **Major**_____

Birth date _____/____/____ **Marital Status**_____ **Sex**_____
Month Day Year

Resident of Clare Hall ❒
Resident – Coventry Apt. ❒
Commuter/Off Campus ❒

Family/Last Name_____ **First Name**_____ **Middle**_____

Home Address_____ **Country**_____
Street City State Zip

Home Phone_____ **Cell Phone**_____ **Email**_____

Emergency Contact_____ **Relationship**_____ **Phone**_____

Father's Name_____ **Age**_____ **Living or Deceased**_____

Mother's Name_____ **Age**_____ **Living or Deceased**_____

Do you have a disability for which your are seeking accommodations? If so, please attach supporting documentation. _____
Are you currently receiving treatment for any medical/emotional condition? (describe) _____
Have you received treatment or counseling for any emotional problems? _____
Past surgeries (describe) _____
Past serious illness/injury (describe) _____
Is there loss of, or seriously impaired function of any organ? (describe) _____

ALLERGIES ***(Check where applicable)*** ❑ No Known Allergies

- ❑ Aspirin
- ❑ Codeine
- ❑ Penicillin
- ❑ Sulfa
- ❑ Insect Bites
- ❑ Animal
- ❑ Environmental / Seasonal
- ❑ Food ***(Please list)*** _____

FAMILY HISTORY (Parents, Siblings, Grandparents) *(Check where applicable)*

- ❑ Alcoholism
- ❑ Anemia
- ❑ Arthritis
- ❑ Blood Disorder
- ❑ Cancer
- ❑ Convulsions
- ❑ Epilepsy
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Mental Illness
- ❑ Migraines
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Other (Specify) _____

PERSONAL HISTORY ***(Check where applicable)***

- ❑ Arthritis
- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anxiety
- ❑ Asthma
- ❑ Bladder / Kidney Infection
- ❑ Blood Disorder
- ❑ Cancer
- ❑ Cardiac Abnormalities
- ❑ Chronic Cough
- ❑ Chronic Kidney Disease
- ❑ Congenital Anomaly
- ❑ Constipation
- ❑ Depression
- ❑ Diabetes
- ❑ Drug Addiction
- ❑ Eating Disorder
- ❑ Emotional Disorder
- ❑ Fainting/Dizziness
- ❑ Frequent Colds
- ❑ Gastrointestinal Problems
- ❑ Head Injury with Loss of Consciousness
- ❑ Headache
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hypertension / High Blood Pressure
- ❑ Insomnia
- ❑ Malaria
- ❑ Mental Illness
- ❑ Migraines
- ❑ Mononucleosis
- ❑ Rheumatoid Disease
- ❑ Seasonal Allergies
- ❑ Seizures / Epilepsy
- ❑ Sexually Transmitted Infection
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Other _____

FEMALES ONLY:

- ❑ Irregular Periods
- ❑ Presently Pregnant
- ❑ Number of Pregnancies _____

MEDICATIONS Currently being used: ***(Check and list where applicable)*** **PLEASE USE A SEPARATE SHEET IF NEEDED**

- ❑ None
- ❑ Over the Counter _____
- ❑ Vitamins _____
- ❑ Prescriptions _____
- ❑ Alcohol (number of drinks per week) _____
- ❑ Tobacco products (type and frequency) _____
- ❑ Oral Contraceptives _____
- ❑ Herbal _____
- ❑ Illicit Drugs _____
- ❑ Other _____

All fulltime undergraduate students in traditional programs, **all** international students and all ADN students participating in clinical settings are automatically enrolled in the student health insurance plan. Any other students may enroll on a voluntary basis. Enrollment forms are available in the Student Health Center or online at
www. studentresources.com

This record is kept confidential in the Student Health Center of the University. Release of information is provided only by written authorization from the student.

IMMUNIZATION HISTORY

Name _____

Directions for Completion:

All students: complete sections A, B, C, F
Athletes: complete sections A, B, C, F (E highly recommended)
College of Nursing students: complete sections A, B, C, E, F, G
International Students: complete sections A, B, C, F, G
Resident Students: complete sections A, B, C, F, G (D and E highly recommended)
Study Abroad & International Programs Participants: consult with the Director of Health Services or International Programs to determine requirements/recommendations.

A **TETANUS-DIPTHERIA**
Primary series completed Date _____
Booster within last 10 years Date _____

B **POLIO**
Primary series completed Date _____
Last Booster Date _____

C **VARICELLA titer or Vaccine** Date _____
Results _____
(Chicken Pox) Had Disease _____

D **MENINGOCOCCAL VACCINE** Date _____

E **HEPATITIS B VACCINE**
#1 _____ #2 _____ #3 _____
OR surface antibody titer Date _____
Results _____
(Please attach copy of results)

F **MMR (Measles, Mumps, Rubella)**
Dose 1– after first birthday Date _____
Dose 2 Date _____

— OR —

RUBELLA if given instead of MMR
Immune titer Date _____ Results _____
(Please attach copy of results)
Vaccine at or after 12 mos. 1. _____ 2. _____

MEASLES (Rubeola) if given instead of MMR
Immune titer Date _____ Results _____
(Please attach copy of results)
Vaccine 1. _____

MUMPS if given instead of MMR
Had Disease _____ Received vaccine _____

G **TUBERCULOSIS SCREENING[1] (This section to be completed by a health care provider.)**

1. Does the student have signs or symptoms of active tuberculosis disease? Yes_____ No_____ If No, proceed to 2. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.
2. Is the student a member of a high-risk group or is the student entering the health professions?[2] Yes _____ No _____
If NO, stop. If Yes, place tuberculin skin test. Please note: *A history of BCG vaccination should not preclude testing of a member of a high-risk group.*
3. 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 _____
4. Chest x-ray (required if tuberculin skin test is positive) result: normal _____ abnormal _____
Date of Chest x-ray: ____/____/____

[1] The American College Health Association has published guidelines on tuberculosis screening of college and university students. These guidelines are based on recommendations from the Centers for Disease Control and the American Thoracic Society. For more information, visit www.acha.org or refer to the CDC's Core Curriculum on tuberculosis available at state health departments or at the following website: www.cdc.gov/nchstp/tb/pubs/corecurr/.

[2] Categories of high risk students include those students who have arrived within the past 5 years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other categories of high-risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal bypass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g., prednisone 15 mg/d for 1 month) or other immunosuppressive disorders.

Name and title of person completing immunization history (please print): _____

Signature _____ **Phone** _____

Effective January 1, 2004, Wisconsin State Law mandates that each public and private post-secondary institution provide information concerning Hepatitis B and meningococcal meningitis to all incoming students. The statute also mandates that acknowledgement of receipt of information and documentation of vaccination or declination of same is maintained on site.

Review and complete enclosed Meningitis and Hepatitis B Immunization Health History form.

Meningococcal Meningitis and Hepatitis B Vaccine Requirement
Cardinal Stritch University

Name: _____ _____ _____
Last First MI

Date of Birth:_____ Social Security Number*_____ Phone (_____)_____

The General Assembly of the State of Wisconsin mandates that each public or private postsecondary institution in the state provide information concerning Hepatitis B infection to all students entering the institution or the first time. Those students who will be living in on-campus housing must also be informed about the risk of meningococcal meningitis infection. The required information below includes the risk factors and dangers of each disease as well as information on the availability and effectiveness of the respective vaccines for persons who are at-risk for the diseases. The information concerning these diseases is from the Centers for Disease control and the American College Health Association.

The law does not require that students receive vaccination for enrollment. Furthermore, the institution is not required by law to provide vaccination and/or reimbursement for the vaccine.

A. Hepatitis B (HBV) Immunization
[TO BE COMPLETED BY ALL NEW STUDENTS]
Hepatitis B (HBV) is a serious viral infection of the liver that can lead to chronic liver disease, cirrhosis, liver cancer, liver failure and even death. The disease is transmitted by blood and or body fluids and many people will have no symptoms when they develop the disease. The Primary risk factors for Hepatitis B are sexual activity and injecting drug use. This disease is completely preventable. Hepatitis B vaccine is available to all age groups to prevent Hepatitis B viral infections. A series of three (3) doses of vaccine are required for optimal protection. Missed doses may still be sought to complete the series if only one or two have been acquired. The HBV Vaccine has a record of safety and is believed to confer lifelong immunity in most cases.

___ I hereby certify that I have read this information and **I have received the initial dose of the Hepatitis B Vaccine**.
___ **Date of initial does of the Hepatitis B vaccine____/____/____**

___ I hereby certify that I have read this information and **I have elected not to receive the Hepatitis B vaccine**.

Signature of Student or Parent/Guardian (If student is under 18): _____ Date _____

B. Meningococcal Meningitis
[TO BE COMPLETED BY NEW STUDENTS LIVING IN UNIVERSITY HOUSEING]
Meningococcal disease is a rare but potentially fatal bacterial infection, expressed as either meningitis (infection of the membranes surrounding the brain and spinal cord) or meningococcemia (bacteria in the blood). Meningococcal disease strikes about 3,000 Americans each year and is responsible for about 300 deaths annually. The disease is spread by airborne transmission, primarily by coughing. The disease can onset very quickly and without warning. Rapid intervention and treatment is required to avoid serious illness and or death. There are 5 different subtypes (called Serogroups) of the bacterium that causes Meningococcal meningitis. The current vaccine does not stimulate protective antibodies to Serogroup B, but it does protect against the most common strains of the disease, including Serogroups A, C, Y, and W-135. The duration of the protection is approximately three to 5 years. The vaccine is very safe and adverse reactions are mild and infrequent, consisting primarily of redness and pain at the site of injection lasting up to two days.
The advisory Committee on Immunization Practices (ACIP) of the U.S. Centers for Disease Control and Prevention (CDC) recommends that college freshmen (particularly those who live in dormitories or residence halls) be informed about meningococcal disease and the benefits of vaccination and those students who wish to reduce their risk for meningococcal disease be immunized. Other undergraduate students who wish to reduce their risk for meningococcal disease may also choose to be vaccinated.

___ I hereby certify that I have read the information and **I have received the vaccine for Meningococcal Meningitis**.
Date of Meningococcal Meningitis vaccine: ____/____/____

___ I hereby certify that I have read this information and **I have elected not to receive the vaccine for Meningococcal Meningitis.**

Signature of Student or Parent/Guardian (If student is under 18): _____ Date _____

For more information about Meningococcal Meningitis and Hepatitis B disease and vaccine, please contact your local health care provider or consult the Center for Disease Control and Prevention Web site at www.cdc.gov/health/default.htm.

* In accordance with the Privacy Act of 1974, please be advised that the requested disclosure of your Social Security Number is voluntary and optional. Your Social Security Number will not be disclosed to individuals or agencies outside of the institution except in accordance with the institutional policy on student records.

PHYSICAL EXAMINATION – CLINICAL EVALUATION

(Required for all nursing students, international students and those participating in Intercollegiate Sports and International Programs.)

Name _____ **Birthdate** _____ **Date of Exam** _____

Age _____ **Sex** _____ **Height** _____ **Weight** _____ Blood Pressure _____ **Pulse** _____ **Respiration** _____
feet/inches **pounds**

Any abnormalities of the following systems?	*Normal*	*Abnormal*
Neck/Thyroid		
Teeth/Gums		
Ears/Nose/Throat		
Head		
Respiratory		
Cardiovascular		
Gastrointestinal		
Hernia		
Eyes		
Genitourinary		
Musculoskeletal/Extremities		
Metabolic/Endocrine		
Neuropsychiatric		
Skin		

NOTES:

Is the student free from communicable disease? ❒Yes ❒No

Explain _____

Is there loss or seriously impaired function of any paired organ? ❒Yes ❒No

Explain _____

Has the student ever used tranquilizers or other psychotropic drugs? ❒Yes ❒No

Explain _____

Does the student have any kind of drug sensitivity? ❒Yes ❒No

Explain _____

Is the student now under treatment for any medical or emotional condition? ❒Yes ❒No

Explain _____

Is the student to continue on medication or allergy injections? ❒Yes** ❒No

**** If yes, please send signed sheet with current instructions.**

Is the student cleared to participate in:

Intramural Sports? ❒Yes ❒No Explain _____

Intercollegiate Athletics? ❒Yes ❒No Explain _____

International Travel? ❒Yes ❒No Explain _____

Nursing Clinicals? ❒Yes ❒No Explain _____

PROVIDER'S SIGNATURE _____

PROVIDER'S NAME (Please Print) _____

PROVIDER'S ADDRESS _____

CITY/STATE/ZIP _____

AREA CODE/PHONE _____

ARE YOU THE PATIENT'S REGULAR HEALTH CARE PROVIDER? ❒YES ❒NO

CONSENT FOR TREATMENT

In the event of a medical need for the undersigned student while at Cardinal Stritch University, I hereby authorize the performance upon said student of such medical procedures as may be deemed necessary by a licensed registered nurse under the direction of the supervising medical director.

Dated this_____day of _____20_____

Student Signature_____

Parent or Guardian (if student is under age 18)

Name (please print)_____

Signature_____

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

Please mail to:

Cardinal Stritch University
Attn: Student Health Center
6801 North Yates Road, Box 505
Milwaukee, WI 53217
or
FAX: 414-410-4094

If you have any questions or need information regarding health insurance available through the University, please contact:
Student Health Center: (414) 410-4096