

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 you 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

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Sulf	<input type="checkbox"/> Environmental / Seasonal
<input type="checkbox"/> Codeine	<input type="checkbox"/> Insect Bites	<input type="checkbox"/> Food (Please list) _____
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Animal	

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

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Migraines	<input type="checkbox"/> Other (Specify) _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Convulsions	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke	

PERSONAL HISTORY (Check where applicable)

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Migraines	FEMALES ONLY:
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Chronic Kidney Disease	<input type="checkbox"/> Gastrointestinal Problems	<input type="checkbox"/> Mononucleosis	
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Congenital Anomaly	<input type="checkbox"/> Head Injury with Loss of Consciousness	<input type="checkbox"/> Rheumatoid Disease	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Constipation	<input type="checkbox"/> Headache	<input type="checkbox"/> Seasonal Allergies	
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seizures / Epilepsy	<input type="checkbox"/> Irregular Periods
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Sexually Transmitted Infection	<input type="checkbox"/> Presently Pregnant
<input type="checkbox"/> Bladder / Kidney Infection	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Hypertension / High Blood Pressure	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Number of Pregnancies _____
<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Emotional Disorder	<input type="checkbox"/> Malaria	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Cardiac Abnormalities	<input type="checkbox"/> Fainting/Dizziness	<input type="checkbox"/> Mental Illness		

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

<input type="checkbox"/> None	<input type="checkbox"/> Tobacco products (type and frequency) _____
<input type="checkbox"/> Over the Counter _____	<input type="checkbox"/> Oral Contraceptives _____
<input type="checkbox"/> Vitamins _____	<input type="checkbox"/> Herbal _____
<input type="checkbox"/> Prescriptions _____	<input type="checkbox"/> Illicit Drugs _____
<input type="checkbox"/> Alcohol (number of drinks per week) _____	<input type="checkbox"/> 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

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-DIPHTHERIA	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 _____
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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 SCREENING¹ (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: <i>A history of BCG vaccination should not preclude testing of a member of a high-risk group.</i>
	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.

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