Dear New Student,

I would like to take this opportunity to introduce you to the Chesley Health and Wellness Center at Illinois College. We are located on the third floor of the Bruner Fitness and Recreation Center. Our philosophy is based on the “wellness” of the whole person. Our goal is to support you during your academic, social and spiritual education while at college. This is your Health Care Certificate. The information that you provide on this form will help us care for you while you are a student at Illinois College. If you have questions about the form, please give us a call at 217.245.3038.

The Physical Exam & Immunization Record must be completed by your health care provider. Be sure that the specific dates of your immunizations for communicable diseases (i.e., measles, mumps, rubella and tetanus diphtheria booster) are indicated, as we need this information to be in compliance with state law. Your physical exam should be done within six months of entrance to the College.

Completion of all items will expedite your progress through new student orientation. Failure to provide the completed Health Care Certificate by the 10th day of classes will result in a nonrefundable $25.00 fee. New students will not be allowed to register for the following semester if these forms are not completed. Mail forms directly to the Chesley Health and Wellness Center in the enclosed envelope by August 1 for fall semester or January 2 for spring semester.

If you have a medical or a special learning condition that requires living or diet accommodations, your health history and physical forms will need to be reviewed earlier by Health Services to be able to receive residential life accommodations. Your forms must be received in Health Services by July 1 if you are enrolling for the fall semester and January 1 if you are enrolling for the spring semester.

Your wellness is our primary concern.

Judy Tonry, APRN, BC
Director of the Chesley Health and Wellness Center
Please complete this Health Care Certificate and return it to the Chesley Health and Wellness Center before August 1 for fall semester or January 2 for spring semester. Permission to register is dependent upon completion of this form. Please call 217.245.3038 if you have questions.

**CHESLEY HEALTH AND WELLNESS CENTER**  
**1101 WEST COLLEGE AVENUE, JACKSONVILLE, IL 62650**

**STUDENT INFORMATION**  
Student’s Name __________________________________________ Entry Term (Semester/Year) ____________

Street Address __________________________________________

City __________________________ State __________ Zip __________

Home Phone __________________________ Student Cell __________________________

Date of Birth __________________________ Sex: ☐ Male ☐ Female Social Security Number __________________________

Person to notify in case of emergency __________________________ Relationship __________________________

Address __________________________________________

Home Phone __________________________ Cell __________________________ Work __________________________

If the above number cannot be reached, notify __________________________ Relationship __________________________

Home Phone __________________________ Cell __________________________ Work __________________________

**INSURANCE INFORMATION**  
Please include a copy of your insurance card (front and back).

In case of treatment as an outpatient at the hospital or should inpatient hospitalization be required, the bill for care will be sent directly to the student, parent or legal guardian unless the name and policy number of insurance coverage is provided. If your son/daughter is covered by such a policy, please fill in the following and attach a front and back copy of the card:

Name of Insured __________________________________________ Social Security Number __________________________

Insurance Company __________________________________________ Policy Number __________________________

Insurance Company Address __________________________________________ Phone __________________________

**CONSENT FOR TREATMENT OF MINOR STUDENTS**

Any person who has reached the age of 18 may, in the State of Illinois, sign his or her own consent for treatment at a hospital or other medical care facility. This is also the case for consenting for counseling and other mental health services. If the student has not reached the age of 18, the following must be signed by the student’s parent/guardian for the student to receive treatment.

I, ___________________________________________ hearby give permission for emergency medical treatment for ________________ should it be necessary before s/he reaches the age of 18.

I, ___________________________________________ hearby give permission for mental health treatment for ________________ should it be necessary before s/he reaches the age of 18.
This is the Health Care Provider Form.

Please give this form to your physician, nurse practitioner or physician’s assistant. This form will also serve as a pre-participation Sports Physical for incoming college athletes.

PROVIDERS
Please fill out and return to:

Illinois College
Chesley Health & Wellness Center
1101 West College Avenue
Jacksonville, IL 62650

Should you have any questions, contact us at 217.245.3038.
TO THE EXAMINING PROVIDER: Please complete the Physical Exam and Immunization Record. This information is necessary in order that the College may best serve the student. *The NCAA mandates that all student athletes have knowledge of their sickle cell trait status before any participation in intercollegiate sports.

Student’s Name [Last] [First] [Middle]  DOB ________  ☐ Male  ☐ Female  ☐ Transgender

Measurements:

<table>
<thead>
<tr>
<th>Temp</th>
<th>Pulse</th>
<th>Resp</th>
<th>BP</th>
<th>Height</th>
<th>cms/inches</th>
<th>Weight</th>
<th>kgs/lbs</th>
<th>BMI</th>
</tr>
</thead>
</table>

Urinalysis: Glucose  Ketone  S.G.  Blood  pH  Protein  Nitrates  Leukocytes  
Hgb or Hct  % (for menstruating females)  Sickle Cell Trait  ☐ Yes  ☐ No (attach documentation)

Visual Acuity: Uncorrected [ ] Right 20/   Left 20/   Corrected [ ] Right 20/   Left 20/   

Are there any abnormalities of the following systems? Please describe fully. Use additional sheet if needed.

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>Not Examined</th>
<th>Comments</th>
</tr>
</thead>
</table>

General Appearance: Marfan stigmata, LOC, nutrition, development, mobility, affect, speech, hygiene

Skin: rash, HSV, lesions suggestive of MRSA, color, tinea corporis, acne

Head: shape, size, symmetry, scalp, TMJ, lesions, hair

Eyes: Lids, conjunctiva, sclera, Extraocular muscles

Visual fields

Pupils: size, reaction to light and accommodation

Fundus

Ears: pinna, canals, TMs, hearing

Nose: patency, nares, sinuses, nasal mucosa, septum, turbinates

Mouth: lips, gums, teeth, mucosa, palate, tongue

Throat: pharynx, tonsils, uvula

Nec: ROM, symmetry, palpation, thyroid, lymph nodes

Breasts: size, symmetry, skin, nipples, palpation, nodes

Chest/Lung: excursion, palpation, percussion, auscultation

Cardiac: PMI, palpation, rate, rhythm, S1, S2, murmurs (standing, supine, +/ Valsalva), gallops, bruits, extra sounds

Abdomen: appearance, bowel sounds, bruits, percussion, palpation, liver, spleen, flank, suprapubic, hernia

Anorectal: perianal, digital rectal, stool guaiac

Female Genitalia:

Internal: vaginal mucosal, cervix

Bimanual: vagina, cervix, uterus, adnexa

Male Genitalia: penis, scrotum, testes, hernia

Lymph Nodes: cervical, subclavicular, axillary, inguinal, other

Musculoskeletal:

Back/Spine: ROM, palpation

Upper Extremity: ROM, strength, palpation of shoulder/arm/elbow/forearm/wrist/hand/fingers

Lower Extremity: ROM, strength, palpation of hip/thigh/knee/leg/ankle/foot/toes

Functional: Duck-walk, single leg hop

Peripheral Vascular:

Upper Extremity: pulses, appearance, temp

Lower Extremity: pulses, appearance, temp, simultaneous femoral and radial pulses

Neurologic: cranial nerves, motor, sensory, cerebellar, reflexes, gait, mental status

ASSESSMENT:
PLAN:

Handouts: ☐ SBE ☐ STE ☐ Nutrition ☐ Other ________________
Recommendations: ☐ Dental ☐ Eye Exam ☐ Gyne Exam ☐ Other ________________
Ordered: ☐ CBC ☐ UA ☐ CMP/BMP ☐ Sickle Cell ☐ Glu ☐ CHOL/HDL ☐ CXR ☐ Other ________________

Immunizations: ☐ MMR ☐ Td/Tdap ☐ IPV ☐ Varicella ☐ Meningococcal ☐ HPV

Is student receiving treatment from physician currently? ☐ Yes ☐ No
If yes, please specify: ________________

Is there loss/seriously impaired function of any paired organ? ________________

Does this student have special dietary requirements? __________ If yes, please specify: ________________

On the basis of this examination, I approve the student’s participation in:
☐ Any intercollegiate sports for one year ☐ Yes ☐ No ☐ Limited
☐ Any physical education activity class with no restrictions
☐ An adapted physical education program to exclude the following activities: ________________
☐ No physical education activity classes for the following reason(s): ________________

IMMUNIZATION RECORD (All dates must have month, day and year)

As of July 1989, all students born after January 1, 1957 registering for the first time at public or private colleges in Illinois must present evidence of immunity against the vaccine-preventable diseases. If no proof of immunization, certification of medical exemption, or statement of religious objection is presented, the student will not be permitted to register for courses. (Public Act 85-1315.) Form recommended by ACHA's Vaccine-Preventable Disease Task Force. *Required for entrance.

A. MMR* (Measles, Mumps, Rubella) Two doses required.
Dose 1 given at ages 12–15 months or later #1 __ __ __
Dose 2 given at least 28 days after first dose #2 __ __ __

B. Polio*
Primary series, doses at least 28 days apart. Three primary series are acceptable. See ACIP website for details.
1. OPV alone (oral Sabin three doses): #1 __ __ __ #2 __ __ __ #3 __ __ __
2. IPV/OPV sequential: IPV #1 __ __ __ IPV #2 __ __ __ OPV #3 __ __ __ OPV #4 __ __ __
3. IPV alone (injected Salk four doses): #1 __ __ __ #2 __ __ __ #3 __ __ __ #4 __ __ __

C. Varicella (highly advisable)
Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or 2 doses of vaccine.
1. History of disease: ☐ Yes ☐ No or Birth in U.S. before 1980: ☐ Yes ☐ No
2. Varicella antibody: __ __ __ Result: ☐ Reactive ☐ Non-reactive
3. Immunization: Dose #1 __ __ __
   Dose #2 given at least 12 weeks after first dose ages 1–12 years and at least 4 weeks after first dose if age 13 years or older __ __ __

D. Tetanus-Diphtheria-Pertussis*
Primary series with DtaP, DTP, DT or Td, and booster with Td or Tdap in the last ten years.
1. Primary series of four doses with DtaP, DTP, Dt or Td: #1 __ __ __ #2 __ __ __ #3 __ __ __ #4 __ __ __
2. Date of most recent booster dose: __ __ __ Type of booster: Td ___ Tdap ___ (Tdap booster recommended for ages 11-64 unless contradicted)

E. Human Papilloma Virus Vaccine (HPV2 or HPV4) (HPV—advisable before sexual debut)
Three doses of vaccine for female or male college students 11–26 years of age at 0, 1 or 2 months and 6 month intervals.
1. Immunization (HPV): #1 __ __ __ #2 __ __ __ #3 __ __ __
   Indicate which preparation: Quadrivalent (HPV4) ☐ or Bivalent (HPV2) ☐
F. Influenza
Date of last dose: __/__/__  TIV ☐ or LAIV ☐

G. Hepatitis A (Highly advisable for International travel)
1. Immunization (Hepatitis A): #1__/__/__ #2__/__/__
2. Immunization (Combined Hepatitis A and B vaccine): #1__/__/__ #2__/__/__ #3__/__/__

H. Hepatitis B (Highly advisable)
Three doses of vaccine or two doses of adult vaccine in adolescents 11–15 years of age, or a positive Hepatitis B surface antibody.
1. Immunization (Hepatitis B)
   a. Dose #1 __/__/__ Adult formulation or __Child formulation
   b. Dose #2 __/__/__ Adult formulation or __Child formulation
   c. Dose #3 __/__/__ Adult formulation or __Child formulation
2. Immunization (Combined Hepatitis A and B vaccine) #1__/__/__ #2__/__/__ #3__/__/__
3. Hepatitis B surface antibody  Date: __/__/__  Result: ☐ Reactive ☐ Non-reactive

I. Pneumococcal Polysaccharide Vaccine
One dose for members of high-risk group: Date: __/__/__

J. Meningococcal Quadrivalent (Highly advisable)
(A,C,Y,W-135) One or two doses for all college students – revaccinate every five years if increased risk continues.
1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible):
   Dose #1: __/__/__  Dose #2: __/__/__
2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available): Date: __/__/__  Date: __/__/__

K. Tuberculosis Screening/Testing
1. Have you ever had a positive TB skin test? ☐ Yes ☐ No
2. Are you a student entering the health professions? ☐ Yes ☐ No
3. Have you ever had close contact with anyone who was sick with TB? ☐ Yes ☐ No
4. Were you born in another country and arrived in the U.S. within the past five years? ☐ Yes ☐ No If yes, please indicate which country ________________
5. Have you ever traveled to/in a country with a high incidence of tuberculosis? ☐ Yes ☐ No
   If yes, please indicate which country ________________

6. Have you ever been vaccinated with BCG? ☐ Yes ☐ No
   If the answer is yes to any question Illinois College requires that a health care provider complete a tuberculosis risk assessment (to be completed within 6 months prior to the start of classes). The form can be downloaded from the IC website. All students who have lived in an at risk country that is listed on the Tuberculosis Screening form must have a TB skin test performed before arrival to Illinois College.
   If the answer to all of the above questions is No, no further testing or further action is required.

7. 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
8. Chest X-ray (required if tuberculin skin test is positive)
   Result: ☐ Normal ☐ Abnormal  Date of chest x-ray: __/__/__

HEALTH CARE PROVIDER CERTIFICATION
Health Care Provider (please print) __________________________________________
Health Care Provider’s Signature __________________________________________ Date __________
Address ________________________________________________________________
Telephone ___________________________ Fax _______________________________
HEALTH HISTORY

1. Do you have any allergies?  □ Yes  □ No  If yes, please identify specific allergies:
   □ Medicines  □ Pollens  □ Food  □ Stinging Insects  □ Other: ____________________________

2. If yes, are you receiving allergy shots?  □ Yes  □ No
   If yes, will the shots continue while attending college?  □ Yes  □ No

3. Give details and dates of all operations and/or hospitalizations (including tonsils and adenoids).  □ None

4. Give details of accidents including dislocations, fractures and any injury with loss of consciousness.  □ None

5. Are you taking any prescription and/or nonprescription medications or supplements (herbal and nutritional)?  □ Yes  □ No
   If yes, please list all prescription and non-prescription medications (Name, dosage, and frequency): ____________________________

6. When was your last dental examination?  ____________________________
   When was your last eye examination?  ____________________________

7. Do you wear glasses/contact lenses?  □ Yes  □ No

8. Have you ever been under the care of a medical specialist during the past year?  □ Yes  □ No
   If yes, indicate the reason: ____________________________

   Name, address and phone of specialist ____________________________
   Dates of Treatment ____________________________

9. Have you ever been under the care of a Mental Health specialist (counselor, psychologist, social worker, psychiatrist) during the past year?  □ Yes  □ No
   If yes, indicate the reason: ____________________________

   Name, address and phone of specialist ____________________________
   Dates of Treatment ____________________________

10. Give age or ages at which you have had any of the following:

    □ Anxiety Disorder  □ Hay Fever  □ Rheumatism  □ Asthma  □ Hearing Loss  □ Sickle Cell Trait  □ Chicken Pox  □ Heart Disease/Murmur/Palpitation  □ Skin Disorders  □ Colitis  □ Hepatitis A, B or C  □ Strep Throat  □ Convulsions  □ Depression  □ Infectious Mononucleosis  □ Strep Throat  □ Cholelithiasis  □ Diabetes  □ Heart Disease/Murmur/Palpitation  □ Stomach Ulcer  □ Chicken Pox  □ Hearing Loss  □ Malaria  □ Strep Throat  □ Colitis  □ Heart Disease/Murmur/Palpitation  □ Tuberculosis  □ Convulsions  □ Depression  □ Infectious Mononucleosis  □ Suicide Attempt  □ Cholelithiasis  □ Diabetes  □ Heart Disease/Murmur/Palpitation  □ Thyroid Disease  □ Epilepsy/Seizures  □ Mumps  □ Tuberculosis  □ German Measles  □ Pneumonia  □ Urinary Tract Infection  □ Other diseases (name) ____________________________
HEALTH HISTORY (continued)

11. Are there any special learning disabilities (history of a 504 or IEP) that will need classroom modifications?  □ Yes  □ No
   If yes, your name will be sent to our ADA coordinator to assist with your transition to college academics.

12. Any family history of medically unexplained or cardiac cause of death under age 50?  □ Yes  □ No
   If yes, please explain: ____________________________________________________________

13. Do you have pain or other trouble with your back, legs, feet, hands or joints?  □ Yes  □ No
   If yes, please explain: ____________________________________________________________

14. Has your weight changed in the past six months?  □ Yes  □ No
   Gain or loss? ___________________________ How much? ___________________________ Why? ___________________________

   Do you have any concerns about food?  □ Yes  □ No
   If yes, please explain: ____________________________________________________________

15. Menstrual history age of onset_____________ Date of last menstrual period _______________________
   Regularity: □ Yes  □ No  Usual interval between periods ________________________________
   Describe flow (heavy, moderate, light) ___________________________________________ How many days: ____________
   Amount of pain (none, mild, moderate, severe) ________________________________
   Do you use medicine to treat the pain?  □ Yes  □ No  Name of medicine ____________________________________________

16. Sexual history:  Active  □ Yes  □ No  Sexual Preference: □ Men □ Women □ Both  Number of partners __________
   Birth control □ Yes  □ No If yes, what type: _____________________________________________
   History of STD □ Yes  □ No  Pregnancy history □ Yes  □ No

CERTIFICATION OF INFORMATION

I certify that the information provided is accurate to the best of my knowledge.

Student Signature ___________________________ Date ___________________________

Parent Signature ___________________________ Date ___________________________

Chesley Health & Wellness Center
1101 West College Avenue  |  Jacksonville, Illinois 62650
217.245.3038