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.

There are two parts to the Required Health Care Form. The first part is the Health History and this form must be completed by you (with your family’s help if needed). The second part is the Physical Exam and Immunization Record which 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 to nine months of entrance to the College. If you are a college athlete, this physical exam must be current enough to last through your playing season. Athletic physicals expire one year after the date performed. This physical exam form will serve as your pre-participation Sports Physical for all incoming college athletes and must be in Health Services before your preseason camp begins. Please use the enclosed form.

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. Please mail both completed forms in the enclosed envelope by **August 15** if you are enrolling for the fall semester and **January 2** if you are enrolling for the spring semester.

If you have a medical or learning condition that requires special housing or dietary accommodations, your health history and physical forms will need to be reviewed earlier by Health Services to be able to receive housing accommodations. Your forms must be received in Health Services by **July 1** if you are enrolling for the fall semester and **January 2** 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 15 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 ________________________________________ Group Number __________________________
ID Number ____________________________ 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, ____________________________ hereby give permission for emergency medical treatment for
____________________________ should it be necessary before s/he reaches the age of 18.

I, ____________________________ hereby give permission for mental health treatment for
____________________________ should it be necessary before s/he reaches the age of 18.
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 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 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/  □ Skin Disorders
    □ Colitis  Palpitation  □ Strep Throat
    □ Convulsions  □ Hepatitis A, B or C  □ Stomach Ulcer
    □ Depression  □ Infectious Mononucleosis  □ Substance Abuse
    □ Diabetes  □ Malaria  □ Suicide Attempt
    □ Digestive Tract Problem  □ Measles  □ Thyroid Disease
    □ Eating Disorder  □ Mumps  □ Tuberculosis
    □ Epilepsy/Seizures  □ Pneumonia  □ Urinary Tract Infection
    □ German Measles  □ Rheumatic Fever

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. Over the past 2 weeks, how often have you been bothered by any of the following problems?
<table>
<thead>
<tr>
<th>Not At All</th>
<th>Several Days</th>
<th>More Than Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
</table>
   1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
   2. Feeling down, depressed or hopeless | 0 | 1 | 2 | 3 |

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

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

15. 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: _________________________________________________________________

16. 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 __________________________

17. Sexual history:  Active  Yes  No  Sexual Preference:  Men  Women  Both  Number of partners ______
   Birth control  Yes  No  If yes, what type: _________________________________________________
   History of STI  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 ______________________
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 ______________________ DOB ____________

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
</table>

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, linea corporis, acne |
| Head: shape, size, symmetry, scalp, TMJ, lesions, hair |
| Eyes: Lids, conjunctiva, sclera |
| Extraocular muscles |
| Visual fields |
| Pupil: size, reaction to light and accommodation |
| Fundi |
| Ears: pinna, canals, TMJs, hearing |
| Nose: patency, nares, sinuses, nasal mucosa, septum, turbinates |
| Mouth: lips, gums, teeth, mucosa, palate, tongue |
| Throat: pharynx, tonsils, uvula |
| Neck: ROM, symmetry, palpation, thyroid, lymph nodes |
| Breasts: size, symmetry, skin, nipples, palpation, nodes |
| Chest/Lung: excision, palpation, percussion, auscultation |
| Cardiac: PMI, palpation, rate, rhythm, S1, S2, murmurs (standing, supine, +/- Valsalva), gallop, 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, hemia |
| Lymph Nodes: cervical, subclavian, axillary, inguinal, other |
| Musculoskeletal: Back/Spine: ROM, palpation |
| Upper extremity: HUK, 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?  ☐ Yes  ☐ No
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 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 ____________________________________________________________
Address ___________________________ Date ______________
Telephone ___________________________ Fax ___________________________