Dear New Student,

We 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 medical hold placement on your student account. New students will not be able to register for the following semester and will not be able to view mid-term or final grades if these forms are not completed. Please mail both completed forms in the enclosed envelope by July 1 if you are enrolling for the fall semester and December 1 if you are enrolling for the spring semester.

Your wellness is our primary concern.

Tami Wright, RN, BSN          Renee Overton
Clinical Liaison          Health Services Coordinator
Please complete this Health Care Certificate and return it to the Chesley Health and Wellness Center before July 1 for fall semester or December 1 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 ___________________________ Preferred Name ___________________________ Entry Term (Semester/Year) ______
Street Address ________________________________________________________________
City __________________________________ State __________ Zip ____________
Home Phone ___________________________ Student Cell ___________________________
Date of Birth ___________________________ Social Security Number ___________________________
Sex:  [ ] Male  [ ] Female  [ ] Transgender

Person to notify in case of medical emergency:
Name ___________________________ Relationship ________________
Address ________________________________________________________________
Home Phone ___________________________ Cell ___________________________ Work ___________________________
If the above number cannot be reached, notify ___________________________ Relationship ___________________________
Home Phone ___________________________ Cell ___________________________ Work ___________________________

Person to notify in case of mental health emergency:  [ ] Same as medical emergency contact  [ ] I do not want to designate at this time
Name ___________________________ Relationship ________________
Address ________________________________________________________________
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.
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__________  □ Male □ Female □ Transgender

Measurements:

Temp _____ Pulse _____ Resp _____ BP _____ Height _____ cms/inches Weight _____ kgs/lbs BMI _____

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></th>
<th>Normal</th>
<th>Abnormal</th>
<th>Not Examined</th>
<th>Comments</th>
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<tbody>
<tr>
<td><strong>General Appearance:</strong></td>
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<tr>
<td>Marfan stigmata, LOC, nutrition, development, mobility, affect, speech, hygiene</td>
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<td><strong>Skin:</strong></td>
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<td>rash, HSV, lesions suggestive of MRSA, color, tinea corporis, acne</td>
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<td><strong>Head:</strong></td>
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<td>shape, size, symmetry, scalp, TMJ, lesions, hair</td>
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<td><strong>Eyes:</strong></td>
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<tr>
<td>Lids, conjunctiva, sclera</td>
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<td>Extraocular muscles</td>
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<tr>
<td>Visual fields</td>
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<tr>
<td>Pupils: size, reaction to light and accommodation</td>
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<td>Fundi</td>
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<td><strong>Ears:</strong></td>
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<td>pinna, canals, TMs, hearing</td>
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<td><strong>Nose:</strong></td>
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<td>patency, nares, sinuses, nasal mucosa, septum, turbinates</td>
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<td><strong>Mouth:</strong></td>
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<td>lips, gums, teeth, mucosa, palate, tongue</td>
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<td>Throat: pharynx, tonsils, uvula</td>
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<tr>
<td>Neck: ROM, symmetry, palpation, thyroid, lymph nodes</td>
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<tr>
<td>Breasts: size, symmetry, skin, nipples, palpation, nodes</td>
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<tr>
<td>Chest/Lung: excursion, palpation, percussion, auscultation</td>
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<td>Cardiac: PMI, palpation, rate, rhythm, S1, S2, murmurs (standing, supine, +/- Valsalva), gallops, bruits, extra sounds</td>
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<tr>
<td>Abdomen: appearance, bowel sounds, bruits, percussion, palpation, liver, spleen, flank, suprapubic, hernia</td>
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<tr>
<td>Anorectal: perianal, digital rectal, stool guaiac</td>
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<tr>
<td>Female Genitalia:</td>
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<tr>
<td>Internal: vaginal mucosal, cervix</td>
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<tr>
<td>Bimanual: vagina, cervix, uterus, adnexa</td>
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<td>Male Genitalia: penis, scrotum, testes, hernia</td>
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<td>Lymph Nodes: cervical, subclavian, axillary, inguinal, other</td>
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<td>Musculoskeletal:</td>
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<td>Back/Spine: ROM, palpation</td>
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<tr>
<td>Upper Extremity: ROM, strength, palpation of shoulder/arm/elbow/forearm/wrist/hand/fingers</td>
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<tr>
<td>Lower Extremity: ROM, strength, palpation of hip/thigh/knee/leg/ankle/foot/toes</td>
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<tr>
<td>Functional: Duck-walk, single leg hop</td>
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</table>
| *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
- Sickled Cell
- Glu
- CHOL/HDL
- CXR
- PPD
- IGRA
- Other ________________

Immunizations:

- MMR
- Td/Tdap
- IPV
- Varicella
- Meningococcal
- HPV
- Hepatitis A
- Hepatitis B

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  
- 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):

TUBERCULOSIS (TB) SCREENING/TESTING

Please answer the following questions:

Have you ever had a positive TB skin test?  
- Yes  
- No

Have you ever been vaccinated with BCG?  
- Yes  
- No

Have you ever had close contact with persons known or suspected to have active TB disease?  
- Yes  
- No

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease?  
- Yes  
- No

(If yes, please CIRCLE the country, below)

Afghanistan  
Argentina  
Armenia  
Azerbaijan  
Bangladesh  
Belgium  
Benin  
Bhutan  
Bolivia (Plurinational State of)  
Bosnia and Herzegovina  
Botswana  
Brazil  
Brunei Darussalam  
Bulgaria  
Burkina Faso  
Burundi  
Cabo Verde  
Cambodia  
Cameroon  
Central African Republic  
Chad  
China  
China, Hong Kong SAR  
China, Macao SAR  
Colombia

Comoros  
Congo  
Côte d’Ivoire  
Democratic People’s Republic of Korea  
Democratic Republic of the Congo  
Djibouti  
Dominican Republic  
Ecuador  
El Salvador  
Equatorial Guinea  
Eritrea  
Estonia  
Ethiopia  
Fiji  
French Polynesia  
Gabon  
Gambia  
Georgia  
Ghana  
Greenland  
Guam  
Guatemala  
Guinea  
Guinea-Bissau  
Guyana  
Haiti  
Honduras  
India  
Indonesia  
Iran (Islamic Republic of)  
Iraq  
Kazakhstan  
Kenya  
Kibati  
Kuwait  
Kyrgyzstan  
Lao People’s Democratic Republic  
Latvia  
Lesotho  
Liberia  
Libya  
Lithuania  
Madagascar  
Malawi  
Malaysia  
Maldives  
Mali  
Marshall Islands  
Mauritania  
Mauritius  
Mexico  
Micronesia (Federated States of)  
Mongolia  
Montenegro  
Morocco  
Mozambique  
Myanmar  
Namibia  
Nauru  
Nepal  
Nicaragua  
Niger  
Nigeria  
Northern Mariana Islands  
Pakistan  
Palau  
Panama  
Papua New Guinea  
Paraguay  
Peru  
Philippines  
Poland  
Portugal  
Qatar  
Republic of Korea  
Republic of Moldova  
Romania  
Russian Federation  
Rwanda  
Saint Vincent and the Grenadines  
Sao Tome and Principe  
Senegal  
Serbia  
Seychelles  
Sierra Leone  
Singapore  
Solomon Islands  
Somalia South Africa  
South Sudan  
Sri Lanka  
Sudan  
Suriname  
Swaziland  
Tajikistan  
Thailand  
Timor-Leste  
Togo  
Trinidad and Tobago  
Tunisia  
Turkmenistan  
Tuvalu  
Uganda  
Ukraine  
United Republic of Tanzania  
Uruguay  
Uzbekistan  
Vanuatu  
Venezuela (Bolivarian Republic of)  
Viet Nam  
Yemen  
Zambia  
Zimbabwe

Have you had frequent or prolonged visits* to one or more of the countries or territories listed on the previous page with a high prevalence of TB disease? (If yes, CHECK the countries or territories, on the previous page)  

- Yes  
- No

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?  

- Yes  
- No

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease?  

- Yes  
- No

Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol?  

- Yes  
- No

If the answer is YES to any of the above questions, Illinois College requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester.

If the answer to all of the above questions is NO, no further testing or further action is required.

* The significance of the travel exposure should be discussed with a health care provider and evaluated.

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

Interferon Gamma Release Assay (IGRA)  
Date Obtained: ___/___/___  
(specify method)  
- QFT-GIT  
- T-Spot  
- other  
Result:  
- Negative  
- Positive  
- Indeterminate  
- Borderline (T-Spot only)

Chest X-ray (required if TST or IGRA or T-Spot is positive)  
Result:  
- Normal  
- Abnormal  
Date of chest x-ray: ___/___/___

**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.

**REQUIRED IMMUNIZATIONS:**

A. MMR* (MEASLES, MUMPS, RUBELLA)  
(Two doses required at least 28 days apart for students born after 1956 and all health care professional students.)  
Dose 1 given at age 12 months or later  
#1 ___/___/___  
Dose 2 given at least 28 days after first dose  
#2 ___/___/___

B. MENINGOCOCCAL QUADRIVALENT*  
(Illinois Law: Students must have had one menactra (conjugate) after age of 16.)  
(A, C, Y, W-135) One or 2 doses for all college students; revaccinate every 5 years if increased risk continues.  
1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).  
   a. Dose #1 ___/___/___  
   b. Dose #2 ___/___/___  
2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available).  Date: ___/___/___
C. TETANUS, DIPHTHERIA, PERTUSSIS*
(Illinois Law: Students must have had a TDAP within the last 10 years)
1. Primary series completed?  Yes  No
   Date of last dose in series: __/__/__
2. Date of most recent booster dose: __/__/__
   Type of booster:  Td  Tdap  *Tdap booster recommended for ages 11-64 unless contraindicated

D. 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):
   a. Dose #1 __/__/__
   b. Dose #2 __/__/__
   c. Dose #3 __/__/__
2. IPV/OPV sequential:
   IPV #1 __/__/__
   IPV #2 __/__/__
   OPV #3 __/__/__
   OPV #4 __/__/__
3. IPV alone (injected Salk four doses):
   a. Dose #1 __/__/__
   b. Dose #2 __/__/__
   c. Dose #3 __/__/__
   d. Dose #4 __/__/__

STRONGLY RECOMMENDED IMMUNIZATIONS:
E. HEPATITIS B
(All college and health care professional students. Three doses of vaccine or two doses of adult vaccine in adolescents 11–15 years of age, or a positive hepatitis B surface antibody meets the requirement.)
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)
   a. Dose #1 __/__/__
   b. Dose #2 __/__/__
   c. Dose #3 __/__/__
3. Hepatitis B surface antibody  Date: __/__/__  Result:  Reactive  Non-reactive

F. INFLUENZA
   Trivalent (IIV3)  Quadrivalent (IIV4)  Recombinant (RIV3)  Live attenuated influenza vaccine (LAIV)
Date of last dose: __/__/__

G. 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.)
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 __/__/__
H. HUMAN PAPILLOMAVIRUS VACCINE (HPV2/HPV4/HPV9)
(Three doses of vaccine for females and males 11–26 years of age at 0, 1–2, and 6 month intervals.)
Immunization (indicate which preparation, if known)
- Quadrivalent (HPV4)
- Bivalent (HPV2)
- 9-valent (HPV9)
a. Dose #1 __/__/__
b. Dose #2 __/__/__
c. Dose #3 __/__/__

I. HEPATITIS A
1. Immunization (Hepatitis A):
   a. Dose #1 __/__/__
   b. Dose #2 __/__/__
2. Immunization (Combined Hepatitis A and B vaccine):
   a. Dose #1 __/__/__
   b. Dose #2 __/__/__
   c. Dose #3 __/__/__

J. PNEUMOCOCCAL POLYSACCHARIDE VACCINE
- PCV 13 Date ___/___
- PPSV 23 Date __/___

K. MENINGOCOCCAL SEROUGROUP B
(Two or three dose series; may be given to any college student or for outbreak control; may be given with quadrivalent meningococcal vaccine at different anatomic site. Must complete series with the same vaccine.)
1. MenB-RC (Bexsero) routine outbreak–related
   a. Dose #1 __/__/__
   b. Dose #2 __/__/__
   OR
1. MenB-FHbp (Trumenba) routine outbreak–related
   a. Dose #1 __/__/__
   b. Dose #2 __/__/__

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 _______
   □ Animals _______  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 _____  □ Hearing Loss _____  □ Skin Disorders _____
    □ Asthma _____  □ Heart Disease/Murmur/Palpitation _____  □ Strep Throat _____
    □ Bipolar Disorder _____  □ Hepatitis A, B or C _____  □ Stomach Ulcer _____
    □ Cancer _____  □ Infectious Mononucleosis _____  □ Substance Abuse _____
    □ Chicken Pox _____  □ Malaria _____  □ Alcohol _____
    □ Colitis _____  □ Measles _____  □ Tobacco _____
    □ Depression _____  □ Mumps _____  □ Other Drugs _____
    □ Diabetes _____  □ Pneumonia _____  □ Suicide Attempt _____
    □ Digestive Tract Problem _____  □ Rheumatic Fever _____  □ Thyroid Disease _____
    □ Eating Disorder _____  □ Post Traumatic Stress Disorder _____  □ Tuberculosis _____
    □ Epilepsy/Seizures _____  □ Rheumatism _____  □ Urinary Tract Infection _____
    □ German Measles _____  □ Hay Fever _____  □ Sickle Cell Trait/Disease _____
    □ Other diseases (name) ________________________________________________________________

Other diseases (name) ________________________________________________________________
11. Any family history of medically unexplained or cardiac cause of death under age 50?  □ Yes  □ No  
   If yes, please explain: 

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

13. 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: 

CERTIFICATION OF INFORMATION

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

Student Signature  ___________________________  Date  ______________

Parent Signature  ___________________________  Date  ______________