HEALTH HISTORY

STUDENT NAME: ____
Last *First* *Middle*

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
Clinical Liaison

Renee Overton
Health Services Coordinator

CHESLEY HEALTH AND WELLNESS CENTER
1101 WEST COLLEGE AVENUE
JACKSONVILLE, IL 62650
217.245.3038

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.

PHYSICAL EXAM & IMMUNIZATION RECORD

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
Last *First* *Middle*

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.

	Normal	Abnormal	Not Examined	Comments
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				
Fundi				
Ears: pinna, canals, TMs, 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: 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, subclavian, 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, simultaneious 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 ❑ 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 ❑ 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): ______________________________

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
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
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
Kiribati
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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2014. Countries and territories with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/.

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

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 ______________

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