Health History

PART 1: STUDENT INFORMATION

Last Name First Name Middle Initial Date of Birth Age

Home Address City State Zip Home Phone

Biological Sex: ☐M ☐F Gender Identity: ☐M ☐F FSC Student ID:_____ Cell phone: _____

☐Freshman ☐Sophomore ☐Junior ☐Senior Email: _____

☐White ☐Black/ African American ☐Hispanic ☐Native American/Alaska Native ☐Asian ☐Native Hawaiian/Pacific Islander

Parent/Guardian Name Phone Cell phone

PART 2: EMERGENCY CONTACT INFORMATON

Name Relationship Email

Home Address City State Zip Phone

Work Name and Address City State Zip Phone

PART 3: MEDICAL HISTORY

Acne	☐Current ☐Past ☐Never	***Fainting**	☐Current ☐Past ☐Never	Migraines/Headache	☐Current ☐Past ☐Never
ADD/ADHD	☐Current ☐Past ☐Never	Gallbladder problems	☐Current ☐Past ☐Never	Mono	☐Current ☐Past ☐Never
AIDS/Positive HIV	☐Current ☐Past ☐Never	Gastrointestinal ulcer	☐Current ☐Past ☐Never	***Neck injury**	☐Current ☐Past ☐Never
Anemia	☐Current ☐Past ☐Never	Genital warts/HPV	☐Current ☐Past ☐Never	Obesity	☐Current ☐Past ☐Never
***Asthma**	☐Current ☐Past ☐Never	Gonorrhea	☐Current ☐Past ☐Never	Ovarian cyst	☐Current ☐Past ☐Never
***Back Injury**	☐Current ☐Past ☐Never	Gout	☐Current ☐Past ☐Never	Pelvic infection	☐Current ☐Past ☐Never
Bladder infection	☐Current ☐Past ☐Never	Hay fever	☐Current ☐Past ☐Never	Pneumonia	☐Current ☐Past ☐Never
Bleeding trait	☐Current ☐Past ☐Never	Hepatitis	☐Current ☐Past ☐Never	Phlebitis	☐Current ☐Past ☐Never
Bronchitis	☐Current ☐Past ☐Never	Hearing loss	☐Current ☐Past ☐Never	Rheumatic fever	☐Current ☐Past ☐Never
Cancer	☐Current ☐Past ☐Never	***Heart murmur**	☐Current ☐Past ☐Never	Rheumatic heart disease	☐Current ☐Past ☐Never
Chlamydia	☐Current ☐Past ☐Never	***Heart problems**	☐Current ☐Past ☐Never	Rheumatoid arthritis	☐Current ☐Past ☐Never
Colitis	☐Current ☐Past ☐Never	Herpes	☐Current ☐Past ☐Never	Ringing in ears	☐Current ☐Past ☐Never
***Concussion**	☐Current ☐Past ☐Never	***High blood pressure**	☐Current ☐Past ☐Never	**Seizures**	☐Current ☐Past ☐Never
***Congenital Heart Disease**	☐Current ☐Past ☐Never	Irritable bowel disease	☐Current ☐Past ☐Never	Sickle cell	☐Current ☐Past ☐Never
***Cystic Fibrosis**	☐Current ☐Past ☐Never	Kidney infections	☐Current ☐Past ☐Never	Sinus problems	☐Current ☐Past ☐Never
Deep vein thrombosis	☐Current ☐Past ☐Never	Kidney stones	☐Current ☐Past ☐Never	Syphilis	☐Current ☐Past ☐Never
Diabetes	☐Current ☐Past ☐Never	***Knee injury**	☐Current ☐Past ☐Never	Thyroid problems	☐Current ☐Past ☐Never
Eczema	☐Current ☐Past ☐Never	Learning disability	☐Current ☐Past ☐Never	Tuberculosis	☐Current ☐Past ☐Never
Eye Problems	☐Current ☐Past ☐Never	Low blood sugar	☐Current ☐Past ☐Never	*Other	☐Current ☐Past ☐Never

Allergies to Medication, food or environment: _____

Allergy shots: ☐Current ☐Past ☐Never **Do you carry an Epi-Pen**: ☐ No ☐ Yes

Current Prescription Medications

Medication Name Purpose prescribing provider Phone number

Medication Name Purpose prescribing provider Phone number

Medication Name Purpose prescribing provider Phone number

Medication Name Purpose prescribing provider Phone number

Student name: _____ **ID#:** _____

(Health History continued)

List any supplements, vitamins or herbs:

_____

Do you see or have you seen a specialist? (neurologist, orthopedist, endocrinologist) ☐ No ☐ Yes

If yes, please provide name and office number of specialist: _____

PART 4: MENTAL HEALTH HISTORY

Anxiety Disorder	☐Current ☐Past ☐Never	Eating Disorder	☐Current ☐Past ☐Never	Mood Swings	☐Current ☐Past ☐Never
Delusions	☐Current ☐Past ☐Never	Emotional illness	☐Current ☐Past ☐Never	Obsessive/compulsive	☐Current ☐Past ☐Never
Depression	☐Current ☐Past ☐Never	Hallucinations	☐Current ☐Past ☐Never	Schizophrenia	☐Current ☐Past ☐Never
Drug Dependency	☐Current ☐Past ☐Never	Mania	☐Current ☐Past ☐Never	Suicide attempt	☐Current ☐Past ☐Never

Counseling, hospitalizations for psychiatric care, inpatient or outpatient addiction treatment with dates: _____

_____

PART5: SOCIAL HISTORY

Tobacco User? ☐Yes / If yes, amount weekly _____

Alcohol? ☐ Yes / If yes, amount weekly _____

Street drugs? ☐ Yes / If yes, amount weekly _____

Do you feel safe in your relationships? _____

_____

Have you ever been screened for Adverse Childhood Experiences? _____

_____

Travel

Travel outside of the U.S. in the past year? □No □Yes / If yes, where? _____

Ever have a positive PPD (Turberculosis test)? ☐ No ☐ Yes: date_____

Ever have a BCG injection (Turberculosis vaccine)? ☐ No ☐ Yes: date_____

Ever had a past treatment for Tuberculosis or chest film for Tuberculosis? ☐ No ☐ Yes / If yes, explain:_____

Female Student Only:

Age of first menstrual period_____ First date of last menstrual period_____ Average days between periods___

Missed periods? ☐No ☐Yes, explain_____

Taking birth control pills ☐No ☐Yes, name_____

Special Accommodation Needs

Contacts: ☐ No ☐ Yes Hearing Aids: ☐ No ☐ Yes

Any assistive devices? ☐ No ☐Yes, if yes please list: _____

PART 6: FAMILY HISTORY

Adopted? ☐ No ☐ Yes

Name	Age	Status of Health (fair, good, poor)	Occupation	If deceased, age and cause of death
Mother:				
Father:				
Siblings:				

The information that I have provided on this health history form is accurate to the best of my knowledge.

_____ _____

Signature of Student or Parent/Guardian Date

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height _____ Weight _____	☐ Male ☐ Female	
BP _____ / _____ (_____ / _____) Pulse _____	Vision R 20/ _____ L 20/ _____	Corrected ☐ Y ☐ N
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

  Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

HE0503 9-2681/0410

Health Insurance Information and Consent to Treatment

HEALTH INSURANCE INFORMATION

Insurance Company Name: _____

Name of Policy Holder: _____

Policy Number: _____ Group Number: _____

Insurance company address: _____

Insurance company phone number: _____

***Attach a copy of the insurance card**

AUTHORIZATION FOR TREATMENT

I understand that all information is maintained confidentially in the Student Health Center but may be shared with the Athletic department for athletes and/or the Travel office for study abroad opportunities.

I have read the Notice of Privacy Practices posted on the Florida Southern College Student Health Center website. I understand that any questions about the privacy practices can be directed to the college's privacy office, V. Terry Dennis, Vice-President of Finance at (863)680 - 4148 or via email at vdennis@flsouthern.edu

I understand that the Student Health Center complies with all reporting of communicable disease requirements by the State of Florida.

I hereby give my consent for medical treatment at the Student Health Center of Florida Southern College.

I understand that many services rendered to me by the nurses and nurse practitioners of the SHC are free of charge.

I understand that my student account may be billed for special testing and prescription medications, if needed, and that I will be responsible for those charges.

_____

Signature of Student Student ID Date

_____

Signature of Parent or Guardian if student is under the age of 18 Date

Mandatory Immunization Health History Form

GENERAL EDUCATION

Section A: Required Immunizations Information

Please note: All titers must include a lab report

1. **MMR / MEASLES, MUMPS, RUBELLA VACCINE:**
   Required for everyone born after Dec. 31, 1956. Two doses are required. You must have received on or after 12 months of age AND in 1971 or later. The second dose must have been received at least 30 days after the first dose AND in 1990 or later. OR Provide lab evidence of immunity by doing a blood test to check for antibodies for Measles, Mumps and Rubella. If you do a blood test, you need to provide the results on a lab form that should be faxed or mailed with the completed Mandatory Immunization Health History Form.

2. **HEPATITIS B VACCINE:**
   Students are required to receive this vaccination OR read the CDC's Vaccine Information Statement and sign Immunization Exemption Release to decline. Read the VIS here: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/hep-b.html .

3. **MENINGOCOCCAL MENINGITIS/ MCV4 (MENACTRA/MENVEO) VACCINE:**
   The Advisory Committee on Immunization Practices (ACIP) currently recommends this vaccine for freshmen planning to live in campus dormitories/residence halls. Students are required to receive this vaccination OR read the CDC's Vaccine Information Statement and sign Immunization Exemption Release to decline. Read the VIS here: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.html .

4. **VACCINE WAIVER REQUIREMENT:**
   May only be waived in the event of a signed religious or medical exemption release form. Students under the age of 18 who are waiving the required immunization must have a parent or guardian sign.

Section B: Recommended Immunizations – Not Required for Matriculation

- **TUBERCULOSIS SCREENING:**
  Required for International Students. Must have completed testing within 12 months of matriculation. Can be met by Tuberculosis screening by Tuberculin Skin Test, TST OR by IGRA, Interferon-based Assay lab test. If either screening is returned positive, then you must get a chest x-ray and submit a copy of the report.
  - **FOR TST (Mantoux):** The result of the TST needs to be recorded in mm in the space provided on the form and whether considered negative or positive.
  - **For Interferon-based Assay, IGRA, (QFT or Tspot):** You must submit a copy of the lab report.
- **Td (Tetanus/Diphtheria) or/and Tdap (Tetanus/Diphtheria/Pertussis):**
  Tdap = Adacel/Boostrix. Booster shot within last 10 years.
- **Varicella (Chickenpox):**
  Provide proof of two doses of Varivax OR provide results of a blood test on a lab form verifying immunity to Chickenpox/Varicella. Please note that all titers must include the lab report.
- **Hepatitis A, HPV, Polio:**
  In this section, you may also list any additional vaccines that were administered.
- **Meningitis B:**
  Please specify whether Bexsero (2 doses) or Trumenba (3 doses) in the space provided. View the CDC VIS at https://www.cdc.gov/vaccines/hcp/vis/vis-statements/mening-serogroup.html

Basic Instructions:

- ☐ **DO NOT WAIT!** Submit documents no later than **Dec. 6, 2020**. Late, incomplete or inaccurate information will prevent move-in to residence hall and/or class attendance.
- ☐ **Include the student's FSC ID on all correspondence**. Print all student information legibly (name, phone, etc.).
- ☐ **MINORS (students under 18):** A parent/guardian signature must be included.
- ☐ Keep a copy for your records.
- ☐ Check FSC account to see if the immunization checklist has been cleared. FSC Health Center does not send confirmation that an individual form has been received.

How to Submit:

- ***EMAIL:** SHC@flsouthern.edu
- **FAX: (863) 687-1377**
  Please do not include a cover sheet or other pages that are not required.
- **MAIL:**
  FSC Student Health Center
  111 Lake Hollingsworth Dr.
  Lakeland, FL 33801

***Please note:** Email sent over the Internet is not necessarily secure. Please be aware that the Florida Southern College or the FSC Student Health Center (SHC) cannot guarantee the confidentiality or security of any information sent over the Internet when using email. FSC and/or the SHC shall not be liable for any breach of confidentiality resulting from such use of email via the Internet.*

FLORIDA SOUTHERN COLLEGE

OFFICE USE ONLY

MRN:_____

General Education Immunization Form

REQUIRED – FSC NUMBER (7 digits):

☐☐☐☐☐☐☐

Name: _____ **First Term of Attendance:** ☐ FALL ☐ SPRING ☐ SUMMER

Date of Birth: _____ **Phone:** _____

SECTION A: Required Immunizations

Vaccine Name	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)	Titer Date & Result (Must include lab report)
1. MMR (Measles, Mumps, Rubella) (2 doses on or after 12 months of age)			--NOT APPLICABLE--	
2. Hepatitis B				
3. MCV4 (MENACTRA/MENVEO) (If vaccine was received before 16 years of age a booster shot is required.)			--NOT APPLICABLE--	

4. Tuberculosis Screening (Required for International Students) *Must have completed testing within 12 months of matriculation.*				
TB Skin Test by TST (Mantoux)	Date Placed	Date Read	MM	**Result:** Neg Pos
OR Interferon-based Assay (QFT or Tspot)	Date	Result	**Submit copy of lab report in English**	
Chest X-ray **(Only if positive TST or Lab Test)**	Date	Result	**Submit copy of x-ray report in English**	

SECTION B: Optional Immunizations – Not Required for Matriculation

Td			--NOT APPLICABLE--		
Tdap (Adacel/Boostrix)			--NOT APPLICABLE--		
Varicella (Chickenpox)				--NOT APPLICABLE--	
Hepatitis A					
HPV (Gardasil or Cervarix)					--NOT APPLICABLE--
Meningitis B	Bexsero			--NOT APPLICABLE--	
	Trumenba				--NOT APPLICABLE--

An official stamp from a doctor's office, clinic or health department AND an authorized signature must appear here or this form will not be approved.

_____ _____ _____

Official Office Stamp Here **Physician or Authorized Signature** **Date**

EMAIL: SHC@flsouthern.edu (No cover sheet) **MAIL: FSC Student Health Center 111 Lake Hollingsworth Dr. Lakeland, FL 33801**