

Return all information to:
 Illinois Wesleyan University
 Arnold Health Service
 PO Box 2900
 Bloomington, IL 61702

Illinois Wesleyan University Arnold Health Service
 Ph. (309) 556-3107 Fax (309) 556-3805

This form is due:
August 1 for Fall Semester
December 1 for Spring Semester and/or May Term

Sex: Male Female

Last Name (Print) _____ First Name _____ Middle _____

Date of Birth _____ Social Security Number _____ E-Mail Address _____ Cell Phone Number _____

Home Address (Number and Street) _____ City or Town _____ State _____ Zip Code _____

Parent or Guardian _____ Cell Phone Number _____ Home Telephone _____

Alternative Emergency Contact – Name, Relationship _____ Cell Phone Number _____ Home Telephone _____

MEDICAL HISTORY TO BE COMPLETED BY STUDENT

Allergies to Drug(s)/Medication(s) No Yes (list) _____

Allergies to foods, nuts, insects, environmental No Yes (list) _____

I am an intercollegiate athlete and I request the attached physical be released to the IWU Athletic Trainer Office.

Have you ever been diagnosed with any of the following: If Yes provide details below:

	Yes	No		Yes	No		Yes	No
Anemia (including sickle cell anemia)			Epilepsy or other seizure disorder			Inflammatory bowel, Crohn's		
Arthritis			Fracture/Dislocation			Kidney or bladder infection, stone		
Asthma			Guillain Barre			Migraine headache		
Bleeding disorder			Head injury			Positive TB test/Tuberculosis		
Cancer (incl. leukemia, Hodgkin's)			Heart murmur/Valve problem			Psychiatric/Psychologist care		
Diabetes			High blood pressure			Thyroid disorder		
Disordered eating (anorexia or bulimia)			Immunodeficiency disorder			Serious accident or injury		
Drug or alcohol dependency			Infectious mononucleosis			Other		

Women's Health				Men's Health			
Condition	Yes	No		Condition	Yes	No	
Removal of breast lump or cyst \breast cancer				Lump or mass in testicle			
Missed periods more than four months							
Excessive flow							

FAMILY MEDICAL HISTORY

Check each item	Yes	No	Relationship		Yes	No	Relationship
Father living				Heart disease			
Mother living				High blood pressure			
Alcoholism				Nervous or mental disorder			
Cancer				Thyroid disease			
Diabetes				Tuberculosis			

Have you consulted or been treated by clinics, healthcare provider(s), healer(s) or other practitioners within the past five years? (Other than routine checkups.) Yes No If Yes, provide details below.

Details _____

Attach additional sheet if necessary.

Signature of Student or Parent/Guardian (if under 18 years of age) _____ Date _____

This information is strictly for the use of the Health Service and will not be released to anyone without your knowledge and written consent.
 Illinois Wesleyan University
 Arnold Health Service

Applicants for admission are required to have the following exam completed no more than six (6) months prior to date of entry.

 Last Name (Print) First Name Middle Date of Birth

HEALTH CARE PROVIDER EXAMINATION

Please correlate the student's medical history with your findings, and record below. All entries must be completed and in English.

Male Female Height _____ Weight _____

Blood Pressure _____ / _____ Pulse _____

Current Medications: _____

Enter "N.E." if not evaluated WNL ABN Give detail of abnormality

Enter "N.E." if not evaluated	WNL	ABN	Give detail of abnormality
Head, Neck, Face and Scalp			
Nose and Sinus			
Mouth, Teeth, Gingiva and Throat			
Eyes			
Ears			
Lungs, Chest and Breast			
Heart			
Abdomen and Viscera (include hernia)			
Endocrine System			
Genito-Urinary System			
Musculoskeletal			
Skin and Lymphatic (include acne)			
Neurological System			
Psychiatric			

Is this individual capable of normal physical activity? (athletics, physical education) Yes No

If no, give reasons and limitations/restrictions on comments line below.

- No disability Physical disability Emotional/psychiatric disability
 Learning disability History of Disordered Eating (anorexia/bulimia)

Comments: _____

I certify I have reviewed the history and immunization information and performed a physical exam on the above named patient and find him/her to be physically and emotionally healthy to the extent of participating in activities related to normal college life.

 Date of Examination

 Health Care Provider's Signature

 Print Name of Health Care Provider

 Address

 Health Care Provider Telephone

 City State Zip Code

IMMUNIZATION RECORD (CONT.)

Last Name (Print)	First Name	Middle	Date of Birth
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Part 4 RECOMMENDED IMMUNIZATIONS

MENINGOCOCCAL TETRAVALENT

(A, C, Y, W-135 / One dose – for college freshmen living in dormitories/residence halls, persons with terminal complement deficiencies or asplenia, laboratory personnel with exposure to aerosolized meningococci, and travelers to hyperendemic or endemic areas of the world. Non-freshmen college students under 25 years of age may choose to be vaccinated to reduce their risk of meningococcal disease.)

Tetavalent conjugate (preferred; data for revaccination pending; administer simultaneously with Tdap if possible):

Date / /
M D Y

Tetavalent polysaccharide (acceptable alternative if conjugate not available; revaccinate every 3-5 years if increased risk continues):

Date / /
M D Y

Date / /
M D Y

QUADRIVALENT HUMAN PAPILLOMAVIRUS VACCINE (HPV)

(Three doses of vaccine for female students 11-26 years of age at 0, 2, and 6 month intervals.)
Immunization (HPV)

#1 / /
M D Y

#2 / /
M D Y

3 / /
M D Y

HEALTH CARE PROVIDER

Print Name of Health Care Provider

Address

Health Care Provider's Signature

City

State Zip Code

Date

Health Care Provider Telephone

Mail completed form to:

Illinois Wesleyan University, Arnold Health Service, P.O. Box 2900, Bloomington, IL 61702-2900

For office use only:

Entered Email/note sent Date _____ Incomplete Completed