*Name*_____ *Year of Enrollment: Fall or Spring*_____

Simpson ID _____*Email* _____

SIMPSON COLLEGE

Student Health Form

Medical History, Physician's Report, and Immunizations

The college requires that all full-time students have a current Student Health Form and record of immunizations on file in the Student Health Services (SHS) Office.

A yearly physical exam is recommended for all students, **but required for athletes**.

Athletic Physicals*:* Student athletes are required to submit proof of an annual physical exam prior to participation in practice/competition. NCAA regulations require that the physical exam be dated within **six months (after April 1, before August 1)** of the athlete's first scheduled practice. Turn completed forms into SHS which will be sent to the Athletic Department.

International students: International Students must complete the Tuberculosis Screening Form found at http://simpson.edu/health-services/ . If the screening form indicates the need for a TB evaluation by a health care provider, that evaluation must take place prior to the student's arrival.

Completed Health Forms: Incoming first year and transfer students should return completed health forms (emergency contacts, medical history, and record of immunization) to Student Health Services at the Office of Student Development.

Please return completed student health forms by August 1 for Fall semester and December 1 for Spring Semester.

Student Health Insurance

- Simpson College requires all **International Students** and **Intercollegiate Student Athletes** to provide proof of health insurance. For all other students, health insurance is not required, but strongly recommended.
- **Athletes** must submit a copy of their insurance card and fill out forms through the electronic records system (ATS) before August 1. Instructions and a check list can be found on the athletics website at: http://simpsonathletics.com/information/athletictraining/forms . For questions, please contact Chris Fertal at chris.fertal@simpson.edu .
- **International Students** will be enrolled and billed health insurance. The current insurance plan can be found at: http://simpson.edu/health-services/student-health-insurance/ **.**
- **If students need to purchase health insurance,** options can be viewed at: http://simpson.edu/health-services/student-health-insurance/ .

For Office Use Only:

Date Received:_____ ☐ ***CRI***

Student Athlete: ☐ ***Yes*** ☐ ***No*** ☐ ***XSHI (EC, V)***

Copy to Athletic Office (date): _____ ☐ ***XSHI (HST)***

Revised 05/2017

SIMPSON COLLEGE

Student Health Records

Student's Name: _____ **Preferred Name**: _____
Last *First* *Middle*

Birth date: M_____D_____Y_____ **Sex**: _____ **Gender**: _____ **International Student**: ____Y ____N Home Country: _____

Do you plan to participate in any Simpson College intercollegiate sports? ____**Y** ____**N** Sport(s) _____

High School Attended: _____

Home Address: _____
Street *City* *State* *Zip* *Personal Cell Phone* *Home Phone*

In case of emergency, please contact:

1. Contact Name: _____ **Relationship**: _____

Contact Phone: Home_____ Work _____ ___ Cell _____

2. Contact Name: _____ **Relationship**: _____

Contact Phone: Home_____ Work _____ Cell _____

3. Contact Name: _____ **Relationship**: _____

Contact Phone: Home_____ Work _____ Cell _____

Medical History - Family

	Birth Year	Occupation	State of Health	Age	Deceased	Have any of your relatives had any of the following?							
Father							Yes	No	Relation		Yes	No	Relation
Mother						Arthritis				Kidney Disease			
Siblings						Asthma, Hay Fever				Mental Health Disorder			
						Cancer				Seizure Disorder			
						Depression				Sickle Cell Anemia			
						Diabetes				Substance Abuse			
						Heart Disease				Tuberculosis			

Medical History – Personal Please check if you have experienced, or have concerns about the following:

Have you had, or are you concerned about?	Yes	No		Yes	No		Yes	No		Yes	No
Anxiety			Eating disorder			Measles (German)			Shortness of breath		
Asthma			Eye trouble			Migraine headaches			Sickle Cell Trait Testing (+/-)		
Attention Deficit Disorder			Frequent indigestion			Mononucleosis			Sinusitis		
Back pain			Gallbladder trouble			Mumps			Stomach//intestinal trouble		
Bronchitis			Gum/tooth trouble			Panic attacks			Strep Throat		
Cancer			Hay fever/seasonal allergy			Pneumonia			Trouble Sleeping		
Chemical dependency			Head injury			Polio			Tuberculosis		
Chest pain/pressure			Heart murmur			Recent wt. gain/loss			Urinary Tract/Kidney problems		
Chicken pox			Heart palpitation			Recurrent colds			Weakness: paralysis		
Chronic cough			Heat Illness			Recurrent diarrhea			***Explain other conditions**		
****Number of Concussions:**			High/low blood pressure			Recurrent headaches					
Depression			Jaundice/Hepatitis			Rheumatic fever					
Diabetes			Joint injury			Scarlet fever					
Dizziness/fainting			Malaria			Sexually Transmitted Infection					
Ear/nose/throat trouble			Measles			Seizure Disorder					

***Please explain any "yes" answers in the Personal Medical History and any other information relevant to your health:**

**** Concussions: Please provide information and dates:**

	Yes	No	Comments
Have you had any illness or injury or surgery which required hospitalization?			
At any time, have any of your activities been restricted due to illness, injury, etc? Please explain if yes.			
Have you ever experienced any personal or emotional difficulties which required professional attention?			**For more information about Mental Health Services, contact Simpson College Counseling Services at 515-961-1556 or visit the web site at http://simpson.edu/counseling-services/ .**
Please list dates for your last: -**Medical Exam** -**Dental exam** -**Eye exam**			
Please list any medications you currently take, including over the counter, and herbal supplements:			
Please list **any allergies and reactions** (including medications, food, and environmental):			

SIMPSON COLLEGE

Physician's Report

Physical examinations are required for all athletes and strongly recommended for non-athletes. Athletic physicals must be conducted within 6 months (after April 1, before August 1) of the first scheduled practice.
Physical forms for athletes need to be submitted by August 1 to be eligible.

Examination

Height _____ Weight_____ Blood Pressure _____/_____

Vision L_____ R_____ Glasses Yes____ No_____

Anisocoria L_____ R_____ Contact Lenses Yes____ No_____

Eye Protection Yes____ No_____

Medical Exam

	Normal	Abnormal	Comments
HEENT Fundoscopic Exam			
Ears			
Mouth			
Throat			
Dental			
Thyroid			
Nodes			
Lungs			
Heart/Murmurs			
Abdomen			
Genitalia			`
Hernia			
Skin			
Body Fat% (opt)			

Labs if indicated_____

Urinalysis Albumin_____ Sugar _____ Sp.Gr._____

Hematocrit _____ or Hemoglobin _____ TB Test _____ Date Read _____

Musculoskeletal

	Normal	Abnormal		Normal	Abnormal
Neck			Quad/Hamstring		
Shoulder			Ankle/feet		
Elbow			Back/spine		
Hands			Toe/Heel Walk		
Wrist			Duck Walk		
Knees					

Comments: _____

Below Required for Athletes

I certify that _____ has been evaluated in the following areas as indicated below to be physically fit to participate in school interscholastic activities:

Medical History: Y/N_____(name) Collision Sports _____Cleared _____**Not Cleared**

Medical Exam: Normal/Abnormal_____(name) Contact Sports _____Cleared _____**Not Cleared**

Musculoskeletal: Normal/Abnormal_____(name) Non-Contact Sports _____Cleared _____**Not Cleared**

If not cleared, reason given: _____ Modifications or exceptions _____

➔ **Attending Physician signature (MD, DO, PA, NP)** _____

Print Name _____ Date _____

SIMPSON COLLEGE

Student Name _____

Immunization History

Please fill in the dates below.

REQUIRED IMMUNIZATIONS

MMR (Measles, Mumps, Rubella)
Dose #1 _____ Dose #2_____

Diphtheria/Tetanus/Pertussis
Date last dose received (within past 10 years) _____

Polio
Date last dose received _____

Meningococcal: MenACWY_____
Dose #1 _____ Dose #2 if required _____

Recommended Immunizations

Meningococcal B
Dose #1 _____ Dose #2 if required _____

Hepatitis B
Dose #1 _____ _____
Dose #2_____
Dose #3_____

Hepatitis A
Dose #1 _____
Dose #2_____

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)
Dose #1_____
Dose #2 (if applicable) _____

History of the disease: _____ Yes _____ No
Varicella antibody: Date_____
Result: _____ Reactive _____ Non-reactive
Birth in the U.S. prior to 1980: _____ Yes _____ No

ALL STUDENTS need to read and sign below:

I certify the information on this health form is true and accurate.

Student Signature _____ Date _____

Parent Signature (required if student is under age 18) _____ Date _____

My signature below indicates I have read the attached information regarding meningitis and its risks to college students. I am aware vaccines are available for meningitis and of the benefits of this vaccine.

Student Signature _____ Date _____

Parent Signature (required if student is under age 18) _____ Date _____

STUDENT ATHLETES ONLY need to read and sign below:

I do not know of any existing physical condition or additional health concerns that would preclude participation in sports. I certify the information on this health form is true and accurate. I approve participation in athletic activities. I authorize Student Health Services to release the information contained within this form to the Athletic Department in order to comply with NCAA regulations.

Student Signature _____ Date _____

Parent Signature (required if student is under age 18) _____ Date _____