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/](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](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, unless students can provide proof of insurance that is 1) written in English, 2) the coverage is comparable to the Global Care Preferred coverage and, 3) the claims office is in the United States. The current insurance plan can be found at: [http://simpson.edu/health-services/student-health-insurance/](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/](http://simpson.edu/health-services/student-health-insurance/).

---

**For Office Use Only:**

Date Received: ________________

Student Athlete: ☐ Yes ☐ No

Copy to Athletic Office (date): ________________

☐ CRI

☐ XSHI (EC, V)

☐ XSHI (HST)

Revised 12/2015
Please list dates for your last:

- Eye exam
- Dental exam
- Medical Exam
- Gastroenterology
- Gynecology
- Urology
- Psychiatric Evaluation
- Pulmonary Function Test
- Allergic testing
- Bone Density
- Allergy testing (Other)

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 any medications you currently take, including over the counter, and herbal supplements.

Please list any allergies and reactions (including medications, food, and environmental):
**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

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Blood Pressure</th>
<th>Glasses</th>
<th>Anisocoria</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes ___</td>
<td>Yes ___</td>
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</tbody>
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**Vision**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Contact Lenses</th>
<th>Eye Protection</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes ___</td>
<td>Yes ___</td>
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</tbody>
</table>

**Medical Exam**

<table>
<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Abnormal</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>HEENT</td>
<td>Fundoscopic Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears</td>
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</tr>
<tr>
<td>Mouth</td>
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<tr>
<td>Throat</td>
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<td></td>
<td></td>
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<tr>
<td>Dental</td>
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<td></td>
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<tr>
<td>Thyroid</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Nodes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart/Murmurs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitalia</td>
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<td></td>
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<tr>
<td>Hernia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body Fat% (opt)</td>
<td></td>
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<td></td>
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</table>

**Labs if indicated**

<table>
<thead>
<tr>
<th>Urinalysis</th>
<th>Albumin</th>
<th>Sugar</th>
<th>Sp.Gr.</th>
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</thead>
<tbody>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Hematocrit</th>
<th>or Hemoglobin</th>
<th>TB Test</th>
<th>Date Read</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

**Musculoskeletal**

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<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Abnormal</th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck</td>
<td></td>
<td>Quad/Hamstring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shoulder</td>
<td></td>
<td>Ankle/feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elbow</td>
<td></td>
<td>Back/spine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hands</td>
<td></td>
<td>Toe/Heel Walk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrist</td>
<td></td>
<td>Duck Walk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knees</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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______________________________**
Student Name ____________________________

Immunization History

Please fill in the dates below.

**REQUIRED IMMUNIZATIONS**

**MMR-TWO DOSES REQUIRED if born after 1957:**
(measles, mumps, rubella)

Dose #1 __________  Dose #2 __________

**TETANUS/DIPHTHERIA/PERTUSSIS**

Date last dose or booster received:

(Within past 10 years) ____________________

**POLIO**

Last dose received (date) ________________

**HIGHLY RECOMMENDED IF LIVING ON CAMPUS**

Meningitis: _____ Initial dose _____ booster

**Meningitis Information Statement:**

To be signed by student, and Parent/Legal Guardian if student is a minor.

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

Student Signature ______________________  Date ________________

Parent Signature ________________________  Date ________________

**Recommended Immunizations**

**Hepatitis B Series**

Dose #1 ________________________________
Dose #2 ________________________________
Dose #3 ________________________________

**Hepatitis A**

Dose #1 ________________________________
Dose #2 ________________________________

**Tuberculosis Screening – International Students Only**

International students are required to complete the Tuberculosis Screening Questionnaire found at [http://simpson.edu/health-services/](http://simpson.edu/health-services/). If indicated by questionnaire, student must obtain TB evaluation by a health care provider prior to arrival in the United States.

Date Given ________________
Date Read ________________  Results (+/-) ________________

**Varicella** (birth in the U.S. before 1980, a history of chickenpox, a positive Varicella antibody, or two doses of vaccine meets the requirement)

History of the disease: _____ Yes _____ No
Birth in the U.S. prior to 1980: _____ Yes _____ No
Varicella antibody: ________
Result: _____ Reactive _____ Non-reactive
Immunization:
Dose #1 ________________________________
Dose #2 ________________________________

**ALL STUDENTS need to read and sign below:**

I hereby state that the information on this health form is true and give permission for Simpson College Student Health Services to release information to the Office of Student Development and to health care providers and facilities who are included in my treatment.

Student Signature ____________________________________________  Date ________________

Parent Signature (required if student is under 21) ____________________________  Date ________________

**STUDENT ATHLETES ONLY need to read and sign below:**

I do not know of any existing physical condition or additional health reason that would preclude participation in sports. I certify that the answers to the above questions are true and accurate. I approve participation in athletic activities. I hereby authorize release to Simpson College Student Health Services and/or athletic medical staff of the information contained in this document. Upon written request, I may receive a copy of this document for my personal health care provider or athletic medical staff.

Student Signature ____________________________________________  Date ________________

Parent Signature (required if student is under 21) ____________________________  Date ________________