

We join others in welcoming you to Carleton College. As part of our effort to provide quality health care to Carleton students, we ask that you take time to PRINT and **thoroughly complete** this **Report of Medical History Form (physical examination required in the past 6 months)**. Having this information readily available allows us to provide for your ongoing health care needs, as well as emergency medical treatment. Please **return this completed form by August 6, 2009**. This will allow us time to review your records and insure that your registration will not be delayed.

**We would particularly like to draw your attention to the section on immunizations. To be compliant with Minnesota State Law, all incoming students are **required to submit:****

- **dates of immunization against tetanus and diphtheria (Td) or Tdap (must have had Td/Tdap within the past 10 years)**
- **dates of immunizations against measles, mumps, rubella (MMR) (need evidence of 2 doses of MMR)**
- **a completed Tuberculosis Risk Assessment on page 5 and if indicated, submit results of a PPD (Mantoux test) within the past 6 months**
- ***International Students* must provide results of a TB mantoux test given within the last 6 months**

We and the American College Health Association also strongly **recommend:**

- **Hepatitis A/B series: [www.immunize.org/catg.d/p4075abc.pdf](http://www.immunize.org/catg.d/p4075abc.pdf)**
- **influenza vaccine clinic will be held on October 27, 2009 on campus.**
- **meningitis vaccine (a brochure will be in your post office box on campus when you arrive) (preferably Menactra, but menamune is acceptable if conjugate menactra not available)**
- **varicella (chicken pox) vaccine for those without history of disease (2 doses of vaccine)**
- **HPV (see Wellness Center website –click on HPV vaccine for info)**

We encourage you to discuss these vaccinations with your home medical provider during your appointment for your college entrance medical examination.

**For students planning to participate in NCAA sports:** Please review and sign the release of information on the bottom of page 8. This will allow The Carleton College Wellness Center providers and athletic trainers to share your health information as needed, and not delay your start of practice schedule.

**Students who have not turned in a completed Report of Medical History form and provided dates of Td or Tdap, MMR immunizations and mantoux test (if required) will not be allowed to register for winter term classes.**

The Wellness Center is closed the month of July. If necessary, contact us before or after July by phone (507) 222-4080, by e-mail at: [Wellness@carleton.edu](mailto:Wellness@carleton.edu) or for additional information view our website at <https://www.Carleton.edu/campus/wellness>

**Report of Medical History Form Due By August 6, 2009**

<b>To the Student:</b> Information provided in this Report of Medical History will be used as a reference for your health care providers while you are a student at Carleton College	<b>Carleton College Wellness Center 1 North College Street Northfield, MN 55057</b>	<b>Must be COMPLETE and returned to The Wellness Center by August 6</b>
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### REPORT OF MEDICAL HISTORY

**Please complete pages 1 & 2 before going to your health care provider for examination**

Last Name (Print)	First Name	Middle	/	Ethnicity	Sex: M F
Home Address		City	State	Zip	Date of Birth
Name, Relationship, of Parent or Guardian		Address		Home Telephone Number	
Parent or Guardian Business Address				Business Telephone	
Emergency Contact Name		Relationship		Work/Home Phone Numbers	

	Age	State of Health	Occupation	Age of Death	Cause of Death	Have any of your relatives ever had any of the following?	Y	N	Relationship
Father						Tuberculosis			
Mother						Diabetes			
Brothers						Kidney Disease			
						Heart Disease			
						Stroke			
						High Blood Pressure			
						Arthritis			
Sisters						Stomach Disease			
						Asthma			
						Hayfever			
						Cancer (list type)			
						Mental Illness/Chem. Dependency			

If you answer **YES** to any Personal History questions, please attach a paper to clarify.

**Personal History:**

1. Have you had any illness/injury, surgery or been hospitalized? Do you have any ongoing or chronic illness? \_\_\_\_\_
  2. Has your physical activity been restricted during the past 5 years (list dates/diagnosis) \_\_\_\_\_  
Do you use any special protective or corrective equipment devices that aren't usually used for sports/position (knee brace, neck roll, foot orthotics, retainer-teeth, hearing aid)? \_\_\_\_\_
  3. Have you received treatment/counseling for mental health related issues? \_\_\_ Do you feel stressed out? \_\_\_ Depressed? \_\_\_  
Are you currently receiving counseling? \_\_\_\_\_
  4. Do you take prescription/non-prescription medications?(list) \_\_\_\_\_  
Do you/have you ever taken supplements or vitamins to help you gain/lose weight or improve performance? \_\_\_\_\_
  5. Do you have any allergies to?  
Medications (list) \_\_\_\_\_  
Food (list) \_\_\_\_\_  
Environmental (list) \_\_\_\_\_  
Latex \_\_\_\_\_
- Have you ever had rash/hives during or after exercise? \_\_\_\_\_
6. If you have any medical/social/emotional health questions you would like to discuss with a Carleton Wellness Center staff member, please call 507-646-4080 to make an appointment for discussion.



# IMMUNIZATION RECORD

## PART I

Name \_\_\_\_\_  
Last Name First Name

Date of Birth \_\_\_/\_\_\_/\_\_\_

## PART II – TO BE COMPLETED WITH YOUR HEALTH CARE PROVIDER. All information must be in English.

### REQUIRED:

#### A. M.M.R. (Measles, Mumps, Rubella) (Two doses required at least 28 days apart for students born after 1956 and all health sciences students.)

1. Dose 1 given at age 12 months or later ..... #1 \_\_\_/\_\_\_/\_\_\_  
M D Y
2. Dose 2 given at least 28 days after first dose ..... #2 \_\_\_/\_\_\_/\_\_\_  
M D Y

#### B. TETANUS-DIPHTHERIA-PERTUSSIS (Primary series with DTaP, DTP, DT, or Td, and booster with Td or Tdap in the last ten years. Health sciences students with patient contact should receive one dose of Tdap at an interval as short as 2 years since last Td as appropriate. Refer to ACIP for details)

##### 1. Primary series of four doses with DTaP, DTP, DT, or Td:

#1 \_\_\_/\_\_\_/\_\_\_ #2 \_\_\_/\_\_\_/\_\_\_ #3 \_\_\_/\_\_\_/\_\_\_ #4 \_\_\_/\_\_\_/\_\_\_  
M D Y M D Y M D Y M D Y

2. Booster: Tdap (preferred) to replace a single dose of Td for booster immunization at least 2-5 years since last dose of Td, depending on age of patient. (Administer with MCV4 simultaneously if possible). .... \_\_\_/\_\_\_/\_\_\_

3. Booster: Td within the last ten years ..... \_\_\_/\_\_\_/\_\_\_

#### C. 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): #1 \_\_\_/\_\_\_/\_\_\_ #2 \_\_\_/\_\_\_/\_\_\_ #3 \_\_\_/\_\_\_/\_\_\_  
M D Y M D Y M D Y
2. IPV/OPV sequential: IPV #1 \_\_\_/\_\_\_/\_\_\_ IPV #2 \_\_\_/\_\_\_/\_\_\_ OPV #3 \_\_\_/\_\_\_/\_\_\_ OPV #4 \_\_\_/\_\_\_/\_\_\_  
M D Y M D Y M D Y M D Y
3. IPV alone (injected Salk four doses): #1 \_\_\_/\_\_\_/\_\_\_ #2 \_\_\_/\_\_\_/\_\_\_ #3 \_\_\_/\_\_\_/\_\_\_ #4 \_\_\_/\_\_\_/\_\_\_  
M D Y M D Y M D Y M D Y

#### D. 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 \_\_\_\_\_  
M D Y

##### 3. Immunization

a. Dose #1 ..... #1 \_\_\_/\_\_\_/\_\_\_  
M D Y

b. Dose #2 given at least 12 weeks after first dose ages 1-12 years. . #2 \_\_\_/\_\_\_/\_\_\_  
and at least 4 weeks after first dose if age 13 years or older M D Y

# IMMUNIZATION RECORD

Name \_\_\_\_\_  
Last Name First Name

## RECOMMENDED:

**E. 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 \_\_\_/\_\_\_/\_\_\_

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

Date \_\_\_/\_\_\_/\_\_\_    \_\_\_/\_\_\_/\_\_\_  
M D Y            M D Y

## F. HEPATITIS A

1. Immunization (hepatitis A)

a. Dose #1 \_\_\_/\_\_\_/\_\_\_ b. Dose #2 \_\_\_/\_\_\_/\_\_\_  
M D Y            M D Y

2. Immunization (Combined hepatitis A and B vaccine)

a. Dose #1 \_\_\_/\_\_\_/\_\_\_ b. Dose #2 \_\_\_/\_\_\_/\_\_\_ c. Dose #3 \_\_\_/\_\_\_/\_\_\_  
M D Y            M D Y            M D Y

**G. HEPATITIS B** (All college and health sciences 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 \_\_\_/\_\_\_/\_\_\_ b. Dose #2 \_\_\_/\_\_\_/\_\_\_ c. Dose #3 \_\_\_/\_\_\_/\_\_\_  
M D Y            M D Y            M D Y

2. Immunization (Combined hepatitis A and B vaccine)

a. Dose #1 \_\_\_/\_\_\_/\_\_\_ b. Dose #2 \_\_\_/\_\_\_/\_\_\_ c. Dose #3 \_\_\_/\_\_\_/\_\_\_  
M D Y            M D Y            M D Y

3. Hepatitis B surface antibody Date \_\_\_/\_\_\_/\_\_\_  
M D Y

Result: Reactive \_\_\_\_\_ Non-reactive \_\_\_\_\_

**H. PNEUMOCOCCAL POLYSACCHARIDE VACCINE** (One dose for members of high-risk groups.)

Date \_\_\_/\_\_\_/\_\_\_  
M D Y

**I. INFLUENZA** ((Trivalent inactivated influenza vaccine or TIV. Live attenuated influenza vaccine or LAIV; licensed for health, nonpregnant persons age 5-49 year old. Annual immunization recommended to avoid influenza complications in high-risk patients, to avoid disruption to academic activities, and to limit transmission to high-risk individuals. Health sciences students with patient contact.)

Date \_\_\_/\_\_\_/\_\_\_    \_\_\_/\_\_\_/\_\_\_    \_\_\_/\_\_\_/\_\_\_    \_\_\_/\_\_\_/\_\_\_    \_\_\_/\_\_\_/\_\_\_  
M D Y            M D Y            M D Y            M D Y            M D Y

**J. QUADRIVALENT HUMAN PAPILLOMAVIRUS VACCINE (HPV)**

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

Immunization (HPV)

a. Dose #1 \_\_\_/\_\_\_/\_\_\_ b. Dose #2 \_\_\_/\_\_\_/\_\_\_ c. Dose #3 \_\_\_/\_\_\_/\_\_\_  
M D Y            M D Y            M D Y



**HEALTH EXAMINATION(within the last 6 months) MUST be filled out by a Medical Provider**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body fat \_\_\_\_\_ (Optional) Pulse \_\_\_\_\_ BP \_\_\_\_/\_\_\_\_  
 Corrected Vision: Rt 20/ \_\_\_\_\_ Lt 20/ \_\_\_\_\_ Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_ Hearing screen: Pass \_\_\_\_ Fail \_\_\_\_

Physical Exam	Normal	Abnormal (Describe)
Appearance:		
Skin		
Eyes, ears, nose, throat		
Lymph nodes		
Neck, thyroid		
Heart/pulses		
Lungs		
Abdomen (include hernia)		
Genitourinary		
Neurological		
Psychological		
Musculoskeletal		
neck		
back		
shoulder/arm		
elbow/forearm		
wrist/hand		
hip/thigh		
knee		
leg/ankle		
foot		

Yes \_\_\_\_ No \_\_\_\_ Is the student now under treatment for any medical or mental health condition? Specify \_\_\_\_\_

Recommendations regarding described abnormalities and/or the care of this student? \_\_\_\_\_

<input type="checkbox"/> <b>Cleared</b> (NCAA sports, club sports, intramurals, PE)	<input type="checkbox"/> <b>Cleared after completing</b> evaluation/rehabilitation for:
<input type="checkbox"/> <b>Not cleared</b> for: _____ Reason: _____	Recommendations: _____ _____ _____

\_\_\_\_\_  
Name of Physician/NP/PA (print or type)

\_\_\_\_\_  
Date(within the past 6 mo.)

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Address

\_\_\_\_\_  
**Signature of Physician/NP/PA**

**REQUIRED Signatures**  
**Read carefully:**

**The Wellness Center is an integrated health, counseling, and disability service. Practitioners within The Wellness Center share client information on a need-to-know basis. This sharing is done to coordinate and maximize client care.**

**E-Mail Consent Form**

The staff of the Carleton College Wellness Center welcomes your contact. We also value your privacy and time and, therefore, offer the following information to help you decide on the best method for communicating with us.

- E-Mail is not a secure medium and, therefore, we cannot guarantee that your e-mail will remain confidential. While we will hold your communications confidentially and will not share any information without your permission, we are unable to control other circumstances in which others may see the text of your message. If you are in any way concerned about the contents of your e-mail being read by someone other than the person you are contacting, you might want to consider alternative ways of contacting that person.
- When we respond to your e-mail, we will respond to the address from which it is sent. If you do not wish others who may have access to the e-mail account you are using to also have access to our response, please consider another means of communication.
- Please be aware that our staff does not maintain 24-hour access to our e-mail accounts and may only check our e-mail once per day or less. If time is of particular concern for you, we encourage you to call our office instead.

We hope that this information is helpful to you as you decide how best to reach our staff. We take your time and confidentiality very seriously and, therefore, want to make sure that you understand the limitations of our use of e-mail technology. Of the two statements listed below, please check the one that you would prefer.

\_\_\_\_\_ I give The Wellness Center staff permission to correspond with me via e-mail. I have read the above e-mail consent form and understand that e-mail correspondence is not a secure medium.

\_\_\_\_\_ I do not give The Wellness Center staff permission to correspond with me via e-mail.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

**For students planning to participate in a NCAA sport: (required signature)**

I do not know of any existing or additional health reason that would preclude my participation in NCAA sports. I certify that the answers to the above questions are true and accurate. I hereby authorize Carleton College Athletic Trainers and Medical Providers to review the information contained in this entire document and information about conditions and injuries occurring over the next 4 years pertaining to athletic participation. I also hereby authorize the Carleton College Athletic Trainers and Medical Providers to share this information with my varsity coaching staff when it affects my ability to practice or compete.

\_\_\_\_\_  
Student Signature (or parent or legal guardian if under 18 years of age)

\_\_\_\_\_  
Date

**CONSENT TO TREAT MINORS-Must be signed if student is under 18**

In the event that I cannot be reached for general medical care, or in an emergency, I hereby give my permission to the physician(s) selected by the college to hospitalize, secure proper medical treatment, and to order injection, anesthesia, and/or surgical procedures. I give permission for the responsible personnel of Carleton College to release to the hospital personnel pertinent information regarding any current health problems or allergies; also, the name(s), address, and telephone number of the parents or guardian for emergency notification.

Parent's signature \_\_\_\_\_ Student's name \_\_\_\_\_ Date \_\_\_\_\_