

Carleton College
One North College Street
Northfield, MN 55057

The Wellness Center
Health, Education, Counseling

1-(507) 222-4080
FAX 1-(507) 222-5038

Welcome to Carleton College!

Please complete this form and return it by **July 15, 2011** to:

The Wellness Center
Carleton College
1 N. College St.
Northfield, MN 55057
Or fax to: 1-507-222-5038

For the section on immunizations, you must:

- Tdap is recommended for all college students regardless of interval since last Td. If unable to get Tdap, submit dates of immunization against tetanus and diphtheria (Td), and you must have had this immunization within the past 10 years.
- Submit dates of immunizations against measles, mumps and rubella (MMR), for which you will need evidence of 2 doses.
- Complete Tuberculosis Risk Assessment in this form and, if indicated, submit results of a Mantoux skin test performed after May 1, 2011.
- Provide results of a Mantoux skin test taken after May 1, 2011 if you have spent more than 3 continuous months outside of the United States.
- **International students:** If possible, complete your required immunizations, mantoux skin test, and chest x-ray before leaving your country. These may cost more in the United States than what you pay in your home country. You need to have a mantoux skin test, even if you have had a BCG. Have this mantoux skin test in your home country before coming to Carleton. If positive, you are **REQUIRED** to have a chest x-ray and bring the results to The Wellness Center at Carleton College when you arrive. If you are not able to get a mantoux skin test or chest x-ray in your home country, you will be able to get one in Northfield after you arrive on campus. Please note: A chest x-ray will be expensive in the United States.
- We offer flu shots and other immunizations numerous times throughout the year, beginning fall term. Check our website for specific dates:
http://apps.carleton.edu/campus/wellness/physical_health/immunizations/

Keep in mind:

- If you do not return this form or comply with all the required immunizations, you will not be allowed to register for winter term classes.
- Athletes: If you do not return this form or comply with all the required immunizations, you will not be allowed to practice or participate in your chosen sport.
- If you have difficulties completing any part of this form, please speak to your medical doctor at your local clinic or hospital.

Please read for your information:

<http://www.health.state.mn.us/divs/idepc/immunize/laws/collegelaw.html#4>

<http://www.health.state.mn.us/divs/idepc/diseases/meningococcal/collegefact.html>

<http://www.health.state.mn.us/divs/idepc/diseases/hepatitis/disease.html>

Carleton College Wellness Center
 1 North College Street
 Northfield, MN 55057
 Phone: 1-507-222-4080 Fax: 1-507-222-5038
Wellness@carleton.edu

**Must be COMPLETED and returned to
 The Wellness Center by
 July 15, 2011**
<http://apps.carleton.edu/campus/wellness/>

REPORT OF MEDICAL HISTORY

Last Name:	First Name:	Middle Name:	Ethnicity/Nationality	Sex
Home Address: Street	City	State/Country	Zip/Postal Code	Birthdate:Month/Day/Year
Name of Parent or Guardian:	Street Address	City	State/Country	Zip/Postal Code
Telephone/Mobile phone number				
Name of Emergency Contact:	Relationship to you	Telephone/Mobile phone number Include the country code if it is an international number		

FAMILY HISTORY

	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						Anemia			
Mother						Arthritis			
Brothers						Asthma			
						Cancer (list type)			
						Diabetes			
						Hay fever/allergies			
						Heart Disease/Heart Attack			
Sisters						High Blood Pressure			
						Kidney Disease			
						Mental Illness/Chemical Dependency			
						Stomach Disease			
						Stroke			
						Thyroid Disease			
						Tuberculosis			

STUDENT'S MEDICAL HISTORY

ALLERGIES: Do you have any allergies to:

Medications (please list) _____

Food _____

Environmental _____

Latex _____

MEDICATIONS TAKEN REGULARLY: (include allergy shots, birth control, pain control, laxatives, vitamins, diet pills, antidepressants, inhalers, etc.)

Name of Provider prescribing medication _____ Phone: _____

Medication/Dosage: _____

Medication/Dosage: _____

SURGERIES/ACCIDENTS/HOSPITALIZATIONS: _____

Name: Last,

First,

Middle

Birth date: Month/Day/Year

Student History:

Y N 1a. Have you had a medical illness or injury since your last check-up or physical exam? Explain yes answers below or on back page.

- Y N b. Do you have an ongoing or chronic illness?
- Y N c. Have you had mononucleosis?
- Y N d. Have you had MRSA (Methillin-Resistant Staphylococcus Aureus)?
- Y N 2a. Have you ever been hospitalized overnight?
- Y N b. Have you ever had surgery?
- Y N 3. Have you ever had a rash or hives develop during or after exercise?
- Y N 4a. Have you ever passed out during or after exercise?
- Y N b. Have you ever been dizzy during or after exercise?
- Y N c. Have you ever had chest pain during or after exercise?
- Y N d. Do you get tired more quickly than your friends do during exercise?
- Y N e. Have you ever had racing of your heart or skipped heartbeats?
- Y N f. Have you ever had high blood pressure or high cholesterol?
- Y N g. Have you ever been told you have a heart murmur?
- Y N h. Has any family member or blood relative died of heart problems or sudden death before age 50?
- Y N i. Have you had a severe viral infection (i.e.: myocarditis or mononucleosis) within the last month?
- Y N j. Has a physician ever denied or restricted your participation in athletics for any heart problems?
- Y N 5a. Do you have any current skin problems (e.g.: itching, rashes, acne, warts, herpes, fungus, or blisters)?
- Y N 6a. Have you ever had a head injury or concussion?
- Y N b. Have you ever been knocked out, become unconscious, or lost your memory?
- Y N c. Have you ever had a seizure?
- Y N d. Do you have frequent or severe headaches?
- Y N e. Have you ever had numbness or tingling in your arms, hands, legs, or feet?
- Y N f. Have you ever had a stinger, burner, or pinched nerve?
- Y N 8. Have you ever become ill from exercising in the heat?
- Y N 7a. Do you cough, wheeze, or have trouble breathing during or after activity?
- Y N b. Do you have asthma?
- Y N c. Do you have seasonal allergies that require medical treatment?

- Y N 8a. Do you use any special protective or corrective equipment devices that aren't usually used for your sport or position (e.g.: knee brace, special neck roll, foot orthotic, retainer on your teeth, hearing aid)?
- Y N 9a. Have you had any problems with your eyes or vision?
- Y N b. Do you wear glasses, contacts, or protective eyewear?
- Y N 10a. Have you ever had a sprain, strain, or swelling after injury?
- Y N b. Have you ever broken or fractured any bones or dislocated any joints?
- Y N c. Have you ever had any other problems with pain or swelling in muscles, tendons, bones, or joints?

If yes, circle appropriate structure and explain:

Head	Neck	Back	Knee
Chest	Shoulder	Upper arm	Shin/Calf
Elbow	Forearm	Wrist	Ankle
Hand	Hip	Thigh	Foot

- Y N 11a. Do you want to weigh different than you do now?
 - Y N b. Do you lose weight regularly to meet weight requirements for your sport?
 - Y N c. Have you ever been treated for an eating disorder?
 - Y N 12. Have you had signs or symptoms of Marfans Syndrome?
- FEMALES ONLY:**
- 13. a. When was your first menstrual period? _____
 - b. When was your most recent menstrual period? _____
 - c. How much time do you usually have from the start of one period to the start of another? _____
 - d. How many periods have you had in the last 12 months? _____
 - e. What was the longest time between periods in the last 12 months _____
 - f. pregnancies –abortions__ miscarriages__
 - g. Birth control method_____ birth control name _____

MALES ONLY:

- Y N 14a. Undescended testicle, testicular mass, lump

CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.

<input type="checkbox"/> Ringing in ear <input type="checkbox"/> Ear infections <input type="checkbox"/> Dizzy spells <input type="checkbox"/> Fainting spells <input type="checkbox"/> Nose bleeds – recurrent <input type="checkbox"/> Sinus trouble <input type="checkbox"/> Sore throats – frequent <input type="checkbox"/> Hoarseness – prolonged <input type="checkbox"/> Hay fever / Allergies <input type="checkbox"/> Pneumonia / Pleurisy <input type="checkbox"/> Bronchitis/Chronic cough <input type="checkbox"/> Irregular pulse <input type="checkbox"/> Palpitations <input type="checkbox"/> Leg pain – when walking <input type="checkbox"/> Cold, numb feet or hands <input type="checkbox"/> Hair loss <input type="checkbox"/> Loss of appetite – recent <input type="checkbox"/> Persistent nausea/Vomiting <input type="checkbox"/> Abdominal pain- chronic <input type="checkbox"/> Gall bladder trouble <input type="checkbox"/> Jaundice / Hepatitis <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Crohn's/Colitis <input type="checkbox"/> Bloody or tarry stools <input type="checkbox"/> Urine infections – frequent <input type="checkbox"/> Sexually transmitted diseases Type _____ <input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Bloody or tarry stools <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia <input type="checkbox"/> Urinating frequently <input type="checkbox"/> with leakage <input type="checkbox"/> with pain <input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney stones <input type="checkbox"/> Anemia <input type="checkbox"/> Bruise easily <input type="checkbox"/> Blood transfusions <input type="checkbox"/> Cancer <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Tremor / hands shaking <input type="checkbox"/> Numbness / tingling sensations <input type="checkbox"/> Headaches – frequent <input type="checkbox"/> Migraines <input type="checkbox"/> Arthritis / Rheumatism <input type="checkbox"/> Back pain - recurrent <input type="checkbox"/> Foot pain <input type="checkbox"/> Tattoos <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Scarlet fever <input type="checkbox"/> Polio <input type="checkbox"/> Mumps <input type="checkbox"/> Measles <input type="checkbox"/> German measles <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Herpes <input type="checkbox"/> Aids / HIV <input type="checkbox"/> Malaria/tropical diseases <input type="checkbox"/> Swollen ankles <input type="checkbox"/> Heartburn <input type="checkbox"/> Peptic ulcer	<input type="checkbox"/> Suicidal attempts <input type="checkbox"/> Sleeping or concentration difficulty <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Agitation <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Self injury/cutting <input type="checkbox"/> Phobias <input type="checkbox"/> Mental illness <input type="checkbox"/> Feelings of worthlessness <input type="checkbox"/> History of alcohol / drug addiction <input type="checkbox"/> Anorexia <input type="checkbox"/> Eating disorder <input type="checkbox"/> Bulimia <input type="checkbox"/> Emotional / physical / sexual abuse SOCIAL HISTORY: Do you now or have you ever consumed: Alcohol <input type="checkbox"/> Y <input type="checkbox"/> N Drinks/wk. ____ Caffeine <input type="checkbox"/> Y <input type="checkbox"/> N Cups/day _ ____ Street Drugs <input type="checkbox"/> Y <input type="checkbox"/> N Cigarettes <input type="checkbox"/> Y <input type="checkbox"/> N pk./day ____
--	---	---

Other: _____

Name: Last,

First,

Middle

Birth date: Month/Day/Year

Immunization Record

Required to be completed and returned to The Wellness Center before the first day of class.

All information must be in English.

REQUIRED IMMUNIZATIONS

Minnesota law requires proof of immunization against Measles, Mumps, Rubella, Tetanus and Diphtheria.

MMR #1

(Age 12 months or older)	mo/day/yr (/ /)	or	Measles #1 Mumps #1 Rubella #1	mo/day/yr (/ /) (/ /) (/ /)	OR Positive Titer results after 5/1/2011 (include copy of lab)
--------------------------	----------------------	----	--------------------------------------	--	---

MMR #2

(minimum of 30 days after #1)	mo/day/yr (/ /)	or	Measles #2 Mumps #2 Rubella #2	mo/day/yr (/ /) (/ /) (/ /)	OR Positive Titer results after 5/1/2011 (include copy of lab)
-------------------------------	----------------------	----	--------------------------------------	--	---

Tetanus Diphtheria and Pertussis

Primary Series completed DTap	mo/day/yr (/ /)		Tetanus iephtheria and accellular Pertussis (required if last TD before 9/1/205)	mo/day/yr (/ /)
Last Tetanus Diphtheria booster	(/ /)			

RECOMMENDED IMMUNIZATIONS

Meningitis 1. ___/___/___ Menomune or Menactra Menevo Other A.C.Y.W-135

Hepatitis A 1. ___/___/___ 2. ___/___/___

Hepatitis B 1. ___/___/___ 2. ___/___/___ 3. ___/___/___

(HPV) Gardasil 1. ___/___/___ 2. ___/___/___ 3. ___/___/___

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 ___/___/___

2. IPV/OPV sequential: IPV #1 ___/___/___ IPV #2 ___/___/___ OPV #3 ___/___/___ OPV #4 ___/___/___

3. IPV alone (injected Salk four doses): #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___

Varicella: Either a history of chicken pox, 2 doses of the vaccine given at least 1 month apart if immunized after age 13, or copy of positive varicella antibody.

History of illness?

Dates of vaccinations: 1. ___/___/___ 2. ___/___/___

Pneumococcal Polysaccharide Vaccine-23 valent Young adults with certain medical conditions: chronic pulmonary disease (including asthma and current history of smoking for college students 19 to 64 years old) ___/___/___

History of reaction to immunization? Yes No Which immunization? _____

CONSCIENTIOUS / RELIGIOUS EXEMPTION

MUST BE NOTARIZED MUST FILL OUT IF UNABLE TO MEET REQUIRED IMMUNIZATIONS DUE TO CONSCIENTIOUS OR RELIGIOUS BELIEF

I hereby certify by notarization that my conscientious or religious belief is opposed to immunizations.

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

Subscribed and sworn to me on the _____ day of _____, 20__.

Signature of Notary

Name: Last,

First,

Middle

Birth date: Month/Day/Year

Tuberculosis (TB) Risk Assessment **REQUIRED**

Risk Factors:	Yes	No
Recent <u>close</u> contact with someone with infectious tuberculosis disease		
Have you ever resided outside of the U.S. for longer than 3 months		
Fibrotic changes on chest (radiograph) x-ray suggesting inactive or past tuberculosis		
HIV/AIDS		
Organ transplant recipient		
Immunosuppressed (equivalent of ≥ 15 mg/day of prednisone)		
History of illicit drug use		
Resident/employee/volunteer in high-risk congregate setting (e.g., correctional facilities, nursing home or other health care facilities)		
Medical condition associated with increased risk of progressing to tuberculosis disease if infected [e.g., diabetes mellitus, silicosis, cancer of the head or neck, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal for the given population)]		
Child or adolescent exposed to adults in high-risk categories (as above)		

www.health.state.mn.us/tb

Tuberculosis Mantoux skin test required if boxes above have been checked yes for one or more risk factors. Also, all students who have resided longer than 3 months continuously outside of The United States are required to have a Mantoux skin test dated after May 1, 2011.

PPD: Date Given: ___/___/___ Mantoux Test Date Read: ___/___/___
month/day/year month/day/year

Result: _____ mm. Record actual mm of induration, transverse diameter; if no induration, write "0"

Chest x-ray or radiography required if Mantoux skin test is >10mm induration

Date _____ Normal _____ Abnormal _____ If chest x-ray/radiography is abnormal, please include letter of treatment from physician.

Name: Last,

First,

Middle

Birth date: Month/Day/Year

Health Examination **REQUIRED within the last 6 months for students participating in NCAA sports. All other students- a health examination is **REQUIRED** within the past 12 months.**

Must be filled out by a Medical Provider

Follow up questions on more sensitive issues:

Circle yes or no

Do you feel stressed out or under a lot of pressure?	Yes or No
Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?	Yes or No
Do you feel safe?	Yes or No
Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?	Yes or No
During the past 30 days, did you use chewing tobacco, snuff, or dip?	Yes or No
During the past 30 days, have you had a least 1 drink of alcohol?	Yes or No
Have you ever taken steroid pills or shots without a doctor's prescription?	Yes or No
Have you ever taken any supplements to help you gain or lose weight or improve your performance?	Yes or No

Height _____ Weight _____ % Body fat _____ (Optional) Pulse _____ Blood Pressure _____ /

Corrected Vision: Right 20/ _____ Left 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		

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

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

REQUIRED [] Cleared-NCAA sports, club sports, intramurals, physical education class	[] Cleared after completing evaluation/rehabilitation for:
[] Not cleared for: _____ Reason: _____	Recommendations: _____ _____

Name of Medical Doctor/NP/PA (print or type)

Date

Telephone Number

Street: City: State

ZIP/Postal Code

Signature of Medical Doctor/Nurse Practitioner/Physician Assistant

Name: Last,

First,

Middle

Birth date: Month/Day/Year

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

Month/Day/Year

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.

I hereby give permission to the Carleton certified athletic trainers, coaches and/or athletic director to contact my specified emergency contact, if I am hospitalized as a result of an injury which occurred while participating in a varsity practice or event.

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

Month/Day/Year

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 _____
Month/Day/Year