CONCORDIA
UNIVERSITY IRVINE

undergraduate health forms

Undergraduate Health Forms

2012–2013 ACADEMIC YEAR

To All New Freshmen and Transfer Students:

Welcome to Concordia University! A completed Health Form must be on file in the Health Center in order to be cleared for final registration. A checklist follows for your convenience.

Checklist:

☐ PAGE 1: Personal information and health history to be filled out by student.

☐ PAGE 2: To be filled out by your doctor, nurse practitioner or physician assistant which includes:

1. Physical exam
2. Required Immunizations and Tuberculosis (TB) Clearance
   - **2 MMR (Measles, Mumps and Rubella) vaccines**
     — Dose #1 given on or after your 1st birthday
     — Dose #2 given at least 28 days after the first dose
     What if you have lost your childhood immunization record? You have 2 options:
     1. A lab test showing positive antibodies to MMR is acceptable.
        You may request this test at your doctor's office on your physical exam.
        Attach lab report to health form.
     2. You may receive the first dose of MMR the day of your physical exam.
   - **Tdap (tetanus, diphtheria, pertussis) vaccination within the last 5 years** (given at age 11-18)
   - **Meningitis vaccination (Groups A/C/Y/W - 135) within the last 5 years** (given at age 16 or older)
     — This is not the same as your childhood meningitis immunizations.
   - **TB skin test (PPD-Mantoux) must be completed within the last 12 months**
     — Chest x-ray and lab tests (IGRA) are acceptable forms of TB clearance
3. Recommended Immunizations
   - Hepatitis A vaccine – 2 doses
   - Hepatitis B vaccine – 3 doses
   - Varicella (chickenpox) vaccine – 1 dose or date of disease

☐ PAGE 3: Pre-participation Physical Questionnaire for athletes only.

☐ HEALTH INSURANCE: Please check our website at www.cui.edu/insurance for up-to-date information regarding the student health insurance requirement.

The original forms must be mailed to the Wellness Center by August 1 for the Fall semester and by December 1 for the Spring semester. Please mail them to:

Concordia University Irvine, Wellness Center, 1530 Concordia West, Irvine, CA 92612

Thank you for taking care of your health requirements and I look forward to meeting you soon!

Sincerely,

Michelle Laabs

Michelle Laabs, MSN, FNP-C
Director of Health Services
Phone & Fax 949.214.3105

CONCORDIA UNIVERSITY IRVINE

Wellness Center | 1530 Concordia West | Irvine, CA 92612
Phone 949.214.3105 | Fax 949.214.3105

STUDENT STATUS

☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior
Previous CUI Student? ☐ Yes ☐ No
Date of last semester:

Undergraduate Student Health History/Physical Exam

LAST NAME: FIRST NAME: MI:
STUDENT ID#: AGE: DATE OF BIRTH:
ADDRESS: CELL PHONE #:
CITY: STATE: ZIP:
EMERGENCY CONTACT & RELATIONSHIP: PHONE:

PERSONAL HISTORY

ALLERGIES: ☐ DRUGS: ☐ FOOD: ☐ BEE/OTHER:

History of injuries &/or operations *(give nature & year)*:

History of previous illness *(give year &/or status)*:

☐ APPENDICITIS ☐ EPILEPSY ☐ PNEUMONIA
☐ ASTHMA ☐ KIDNEY DISEASE ☐ RHEUMATIC FEVER
☐ CARDIAC CONDITION ☐ VARICELLA (CHICKEN POX) ☐ SEASONAL ALLERGIES
☐ DIABETES ☐ MONONUCLEOSIS ☐ TUBERCULOSIS

Have you had any other severe illness not mentioned above? If so, please explain.

Have you ever been diagnosed with an eating disorder?

Have you ever been diagnosed with psychological problems? If so, please explain.

Are you using psychoactive or addicting drugs, with or without a prescription? If so, please explain and state drug name.

FAMILY HISTORY

NAME	ALIVE	CHRONIC ILLNESSES?	DECEASED	CAUSE OF DEATH
FATHER				
MOTHER				
BROTHER(S)				
SISTER(S)				
SPOUSE				
CHILDREN				

Have any of your family or blood relatives ever had any of the following illnesses? Please give relationship.

ASTHMA:	HIGH BLOOD PRESSURE:
CANCER (TYPE):	KIDNEY DISEASE:
DIABETES:	MENTAL DISTURBANCES:
HEART DISEASE:	TUBERCULOSIS:
ANY CHRONIC ILLNESSES NOT MENTIONED?	

CONSENT FOR TREATMENT AND EXCHANGE OF HEALTH INFORMATION

In case of illness and/or injury, authority and consent is given to the university medical staff for examination and treatment of the named student either at the Concordia University Irvine (CUI) Health Center or by outside physicians and medical facilities as are available. Consent is further given for CUI medical staff to exchange medical & mental health information with CUI psychological counseling staff, as needed. It is agreed that all medical and/or hospital expenses incurred beyond those covered by an applicable student insurance policy will be paid directly and promptly by the undersigned student and parents or guardians and the university will not be held responsible.

STUDENT SIGNATURE: DATE:

If under 18, parent/guardian signature

CONCORDIA UNIVERSITY IRVINE

Health Record and Examination

To be completed by M.D./N.P./P.A.

LAST NAME: FIRST NAME: MI:

DATE OF BIRTH: AGE: SEX: STUDENT ID#: E

BLOOD PRESSURE: PULSE RATE: HEIGHT: WEIGHT:

VISION: R20/ L20/ CORRECTED: ☐ Y ☐ N PUPILS EQUAL: ☐ Y ☐ N

ALLERGIES: ☐ DRUGS: ☐ FOOD: ☐ BEE/OTHER:

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
APPEARANCE			
EYES/EARS/NOSE/THROAT			
LYMPH NODES			
HEART			
PULSES			
LUNGS			
ABDOMEN			
GENITALS (MALES ONLY)			
SKIN			
MUSCULOSKELETAL			
NECK			
BACK			
SHOULDER/ARM			
ELBOW/FOREARM			
WRIST/HAND			
HIP/THIGH			
KNEE			
LEG/ANKLE			
FOOT			

CLEARANCE

☐ CLEARED ☐ CLEARED AFTER COMPLETING EVALUATION/REHABILITATION FOR:

☐ NOT CLEARED FOR: REASON:

RECOMMENDATIONS:

REQUIRED IMMUNIZATIONS AND TUBERCULIN TEST

☐ **MMR** (Measles, Mumps, Rubella) – 2 Doses Required
- Given on or after first birthday DOSE #1 ____ / ____ / ____
- Given at least 28 days after the first dose DOSE #2 ____ / ____ / ____

☐ **TDAP** (Tetanus, diphtheria, pertussis) given within the last 5 years ____ / ____ / ____

☐ **MENINGITIS** (Groups A/C/Y/W – 135) given within the last 5 years ____ / ____ / ____

☐ **TUBERCULIN TEST** (PPD-Mantoux) completed within the last 12 months

DATE GIVEN: ____ / ____ / ____ DATE READ: ____ / ____ / ____ RESULT: ____ MM INDURATION ☐ NEGATIVE ☐ POSITIVE

If positive, please obtain chest x-ray and send copy of report.

RECOMMENDED IMMUNIZATIONS

☐ **HEPATITIS A** DOSE #1 ____ / ____ / ____ DOSE #2 ____ / ____ / ____

☐ **HEPATITIS B** DOSE #1 ____ / ____ / ____ DOSE #2 ____ / ____ / ____ DOSE #3 ____ / ____ / ____

☐ **VARICELLA (Chicken Pox)** DOSE #1 ____ / ____ / ____ DOSE #2 ____ / ____ / ____ DISEASE DATE ____ / ____ / ____

**** If student is unimmunized due to religious, personal, or medical reasons, please notify us.*

HEALTHCARE PROVIDER'S SIGNATURE: DATE:

(Not valid without office stamp)

CONCORDIA UNIVERSITY IRVINE

DATE:

Athletic Pre-Participation Physical Questionnaire

(For Athletes Only)

NAME: SEX: AGE: DATE OF BIRTH:

GRADE: SCHOOL: SPORT(S):

ADDRESS: PHONE:

PERSONAL PHYSICIAN:

IN CASE OF EMERGENCY: NAME: RELATIONSHIP: PHONE: (H) (W)

EXPLAIN "YES" ANSWERS BELOW. CIRCLE QUESTIONS YOU DON'T KNOW THE ANSWERS TO.

	YES	NO
1. Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
Do you have an ongoing or chronic illness?	☐	☐
2. Have you ever been hospitalized overnight?	☐	☐
Have you ever had surgery?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	☐	☐
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
4. Do you have any allergies (pollen, medicine, food or stinging insects)?	☐	☐
Have you ever had a rash or hives develop during or after exercise?	☐	☐
5. Have you ever passed out during or after exercise?	☐	☐
Have you ever been dizzy during or after exercise?	☐	☐
Have you ever had chest pain during or after exercise?	☐	☐
Do you get tired more quickly than your friends do during exercise?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Have you had high blood pressure or high cholesterol?	☐	☐
Have you ever had a heart murmur?	☐	☐
Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
Have you had a severe viral infection (myocarditis or mononucleosis) within the last month?	☐	☐
Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
6. Do you have any current skin problems (itching, rashes, acne, warts, fungus or blisters)?	☐	☐
7. Have you ever had a head injury or concussion?	☐	☐
Have you ever been knocked out, become unconscious or lost your memory?	☐	☐
Have you ever had a seizure?	☐	☐
Do you have frequent or severe headaches?	☐	☐
Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
Have you ever had a stinger, burner or pinched nerve?	☐	☐
8. Have you ever become ill from exercising in the heat?	☐	☐

	YES	NO
9. Do you cough, wheeze or have trouble breathing during or after activity?	☐	☐
Do you have asthma?	☐	☐
Do you have seasonal allergies that require medical treatment?	☐	☐
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your support or position (knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
11. Have you had any problems with your eyes or vision?	☐	☐
Do you wear glasses, contacts or protective eyewear?	☐	☐
12. Have you ever had a sprain, strain or swelling after injury?	☐	☐
Have you broken or fractured any bones or dislocated any joints?	☐	☐
Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	☐	☐
If YES, check appropriate box and explain below.		
☐ Head ☐ Elbow ☐ Hip ☐ Neck ☐ Forearm		
☐ Thigh ☐ Back ☐ Wrist ☐ Knee ☐ Chest		
☐ Hand ☐ Shin/Calf ☐ Shoulder ☐ Finger		
☐ Ankle ☐ Upper arm ☐ Foot		
13. Do you want to weigh more or less than you do now?	☐	☐
Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
14. Do you feel stressed out?	☐	☐
15. FEMALES ONLY		
When was your first menstrual period? _____		
Most recent menstrual period? _____		
How much time usually passes from the start of one period to the start of another? _____		
How many periods have you had in the last year? _____		
What was the longest time between periods in the last year? _____		

EXPLAIN ALL "YES" ANSWERS HERE:

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

SIGNATURE OF ATHLETE: SIGNATURE OF PARENT/GUARDIAN:

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