



WALDORF COLLEGE

Student Health Evaluation Form

**Waldorf Student Health Services
106 S. 6th Street
Forest City, IA 50436**

Waldorf College **requires** all students to complete this form. If you participate in athletics you will need to have a physical done every year prior to your athletic's sport season.

RELEASE OF INFORMATION

The Waldorf Student Health Services assures that all medical information received is confidential and will be released only as necessary for the student's health and welfare. My (Our) signature on this form authorizes the release of information between the Director of the Student Health Services, athletic trainer, coaches, and health care providers.

It also authorizes the release of medical information between any other health care providers providing care to registered Waldorf College students.

This authorization for Release of Information will remain in effect from the date on which this form is signed throughout the student's enrollment at Waldorf College. I (We) understand we may revoke this authorization at any time by giving written notice to the Student Health Service.

Student _____
(Please print)

Student _____
SIGNATURE (Required)

Parent (or Guardian) _____
SIGNATURE (Required if student is under age 18)

Waldorf College Student Health Services
1-641-585-8157
Fax: 1-641-585-8194
E-mail: mathiasem@waldorf.edu

PLEASE RETURN THIS FORM TO:
Admission Office
Waldorf College
106 S. 6th St.
Forest City, Iowa 50436

PART 1 INFORMATION TO BE COMPLETED BY THE STUDENT

Drug Allergies _____

Date of entry to Waldorf _____ Entering as: First-year student Transfer student Returning student
 Month Year

1A IDENTIFICATION

Social Security Number _____ Date of Birth _____

Living on campus Living off campus (Forest City address) Commuting to Waldorf

SEX: M F

LAST NAME (Print)	FIRST NAME	MIDDLE	()
HOME ADDRESS (Number and Street)	CITY	STATE	ZIP CODE COUNTY (Area Code) TELEPHONE

COUNTRY OF CITIZENSHIP _____ COUNTRY OF RESIDENCE _____

MARITAL STATUS: Single Married Other

1B NOTIFY IN EMERGENCY (Two phone numbers required)

NAME, ADDRESS, RELATIONSHIP _____ a. ()
 Area Code

NAME, ADDRESS, RELATIONSHIP _____ b. ()
 Area Code

Email address: _____

1C FAMILY HISTORY

Given Name	State of Health	Age at Death	Cause of Death	Marital Status
Father				
Mother				
Brothers				
Sisters				

Have any of your relatives ever had any of the following?

	Yes	No	Relationship
Emotional Problems			
Sickle Cell Trait			
Tuberculosis			
Diabetes			
Kidney Disease			
Cancer			
Arthritis			
Heart Disease			
Asthma, Hay Fever			
Epilepsy, Convulsive Disorders			
High Blood Pressure			
Sudden death before age 50			

1D PERSONAL HISTORY PLEASE RESPOND TO ALL QUESTIONS If yes, give specifics on back.

HAVE YOU HAD?	YES	NO		YES	NO		YES	NO		YES	NO
Scarlet Fever			Skin Problems			Disease, dislocation, or fracture of any bones or joints			Tumor, Cancer, Cyst		
Malaria			Allergy to any of the following?			Pain or swelling in muscles, tendons, bones, or joints			Hepatitis		
Gum or Tooth Trouble			a. Medications						Stomach or Intestinal Trouble		
Sinusitis			b. Foods (List)						a. Recurrent Diarrhea		
Eye Trouble			c. Other (specify)						Mononucleosis		
Ear, Nose, Throat Trouble			Hay Fever			a. Head			Gallbladder Trouble or Gallstones		
Drug/Alcohol Problems			Asthma			b. Neck			Rupture, Hernia		
Siezuers/Convulsions			a. Shortness of Breath			c. Back			Recent Gain or Loss of Weight		
Polio			b. Coughing			d. Chest			a. Want to weigh more		
Insomnia			c. Wheezing			e. Shoulder			b. Want to weigh less		
Frequent Anxiety			Tuberculosis			f. Upper Arm			c. Lose weight regularly for weight requirements for your sport		
a. Feel stressed out			Pain/Pressure in Chest			g. Elbow			Eating Disorders		
Frequent Depression			Chronic Cough			h. Forearm			Sex, Transmitted Disease (specify)		
Worry or Nervousness			Irregular heartbeats/rhythms			i. Wrist			Albumin-Sugar in Urine		
Recurrent Headaches			High Blood Pressure			j. Hand			Blood in Urine		
Migraines			a. Numbness or tingling in hands, arms, legs, or feet?			k. Finger			Diabetes		
Head Injury or Concussion			b. Pinched nerve			l. Hip			Pneumonia		
Dizziness, Fainting			Rheumatic Fever or Heart Murmur			m. Thigh					
Weakness, Paralysis						n. Knee					
Unconsciousness or Memory Loss						o. Shin/Calf					
						p. Ankle					
						q. Foot					

1E STUDENT QUESTIONS

	YES	NO	DETAILS
A. Do you have physical limitations			
Has a physician ever denied or restricted your participation in sports due to heart or any other medical problems?			
Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?			
B. Do you take any prescription drugs?			
Do you take any over-the-counter medications?			
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?			
C. Has your physical activity been restricted during the past five years? (Give reasons and durations)			
D. Have you received treatment or counseling for a personality/character disorder or emotional condition? (List condition, medicines, hospitalization, etc.)			
E. Have you had any illness, injury, or been hospitalized for other conditions?			
Have you had a medical illness or injury since your last checkup or sports physical? (Give details)			
F. Have you ever been hospitalized overnight?			
Have you ever had surgery?			
G. Have you been outside your native country? If so, when and where?			
H. FEMALES ONLY			
Irregular Periods			
Period every month			
More than one period per month			
Severe Cramps			
Excessive Flow			
Do you generally flow more than five days?			
Are you pregnant?			
I. Have you ever had a rash or hives develop during or after exercise?			
J. 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 during exercise?			
Have you ever become ill from exercising in the heat?			

PART 2 THIS INFORMATION MUST BE COMPLETED BY A HEALTH CARE PROVIDER

2A IMMUNIZATION HISTORY

REQUIRED

M.M.R. (Measles, Mumps, Rubella)

12 months or older #1 _____
 5 years or older #2 _____

If given separately:

Measles 1st _____
 2nd _____

Mumps 1st _____

Rubella 1st _____

Tetanus-Diphtheria

Date primary series completed _____
 Last booster _____

Polio

Date primary series completed _____
 Booster _____

Varicella (Chicken Pox)

Had disease Yes ___ No ___ If **no**, 2 doses required one month apart
 (If vaccinated before age 13, Vaccinated 1st _____
 only one dose required; 2nd _____
 after age 13, two doses required.)

DATE GIVEN REQUIRED

Tuberculosis Screening

PPD or Mantoux (BCG not accepted) Date given _____
 Must be within past 12 months

Results: positive negative _____ mm induration

Chest X-ray _____ Date given _____
 (If positive, chest x-ray required.) Results _____

RECOMMENDED

Hepatitis B

1st _____
 2nd _____
 3rd _____

Meningitis

The American College Health Association **recommends** that students consider a meningitis vaccine to reduce the risk for potentially fatal bacterial meningitis. (For questions, see enclosed meningitis letter and consult your health care provider.)

Hepatitis A

1st _____
 2nd _____

OTHER IMMUNIZATIONS (May be received after enrollment for travel, influenza, etc.)

TYPE	DOSE	DATE GIVEN
_____	_____	_____
_____	_____	_____
_____	_____	_____

2B EVALUATION BY HEALTH CARE PROVIDER

REQUIRED

Ht. _____ Wt. _____ % Body Fat (opt.) _____ B.P. ____/____ Pulse _____ Urinalysis (required for all) Alb. _____ Sug. _____

Vision: R 20/____ L 20/____ Corrected Yes No Prescription lenses Yes No Contact lenses Yes No

Pupils: Equal _____ Unequal _____

AS INDICATED

Hemoglobin _____ gms/% Serology (VDRL) Date _____ Results _____ Sickle Cell (if indicated) Neg. _____ Pos. _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Station-based examination only

Recommendations for physical activity

Unlimited _____ Limited _____ Recommendations _____

2C HEALTH CARE PROVIDER (Signature required)

Name (print) _____ Address _____

Signature _____ Phone _____ Date _____

2D INSURANCE DATA

Do you have health coverage under a family or individual policy? Yes No

Company Name _____ Policy No. _____ Group No. _____

Policy Holder _____ Policy Holder's Birth Date _____

Claims No. _____ Claims Address _____

It is important that you carry a copy of the policyholder's insurance card. This information will be needed should you require health care outside of Student Health Services. Please include a photocopy of both the front and back of the policyholder's card.