

WINGATE UNIVERSITY

STUDENT HEALTH SERVICES HEALTH INFORMATION SUMMARY

Wingate University is interested in every phase of student life. An active Health Service is available when residence halls are open, and every effort is made to provide excellent health care. In order that this may be carried out properly, we ask that this form be completed. Confidentiality is a high priority. Student Health records will not be revealed without permission of the student, except as appropriate to other physicians, or by court order. All students must sign the authorization and consent below. If the student is under the age of 18, the parents or guardian must also sign. **COMPLETED FORM IS REQUIRED PRIOR TO REGISTRATION.**

TO THE STUDENTS AND PARENTS: Incomplete Forms Will Be Returned - Please type or print with ink. Please mail the completed form by July 1 to: DIRECTOR, STUDENT HEALTH SERVICE, Box 3037, Wingate, North Carolina 28174. Telephone Number (704) 233-8102. Email: s.mccaskill@wingate.edu Notice **DO NOT MAIL UNTIL ALL PROCEDURES ARE COMPLETED AND ENTERED ON THE FORM.**

-PLEASE PRINT OR TYPE-

Full Name _____ Social Sec. # _____

_____ Last _____ First _____ Middle _____
Date of Birth ____/____/____ Marital Status _____ Sex ____ Age ____

Admissions Status: Entering Date _____ New Student Transfer Readmit - Year last attended _____

Fr. Soph. Jr. Sr. Pharm PA

Home Address _____ () _____
_____ Street _____ City _____ State _____ Zip Code _____ Telephone No. _____

Name and Relationship or Next of Kin _____ Home Telephone Number _____

Address of Next of Kin _____

Next of Kin's Business Address _____ Business Telephone _____

PREVIOUS COLLEGES ATTENDED:

| Name | Place | Inclusive Dates |
|-------|-------|-----------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

USA CITIZEN? Yes No If no, what is your nationality _____

AUTHORIZATION AND CONSENT:

I hereby agree that the attending physician or whomever he or she may designate may undertake treatment, including operations and/or the administration of necessary anesthesia, in serious or major illnesses or injuries without prior notification of the undersigned or any other person and without obtaining consent of the undersigned or any other person, if in the judgement of the physician or designee it is necessary for health care reasons to proceed with the treatment without delay. I further agree that the attending physicians or whomever he or she may designate may evaluate and treat all other injuries or illnesses for which help is sought. In the case of a minor student, this treatment may proceed without prior notification of the undersigned parent or guardian. I also agree that needed immunizations may be administered. I further agree that the Student Health Service may release any medical information to other health care providers who may be providing care.

Date _____ Signature of Student _____

*Signature of minor's parent / guardian _____

I hereby give my permission to Student Health Service to inform Resident Life / Housing Office of _____

_____ which requires special housing consideration.

(health problem)

Signature _____

HEALTH INSURANCE INFORMATION REQUIRED OR SUBMIT COPY OF BOTH SIDES OF INS. ID CARD.

Name of Ins. Co. _____ Subscriber's ID No. _____ Group # _____

Address of Ins. Co. _____ Subscriber's Name _____

Subscriber's DOB _____ SS# _____

Is PREADMISSION CERTIFICATION required by your insurance carrier? Yes No

If preadmission certification required, give phone number to call: (_____) _____

Please check if policy is HMO _____ PPO _____ Neither _____

*A minor is a person under 18 years of age in North Carolina.

MEDICAL HISTORY
 PLEASE COMPLETE THIS BEFORE GOING TO YOUR PHYSICIAN FOR EXAMINATION
 -PLEASE PRINT OR TYPE-

FAMILY HISTORY

| | Age | State of Health | Occupation | Age of Death | Cause of Death |
|----------|-----|-----------------|------------|--------------|----------------|
| Father | | | | | |
| Mother | | | | | |
| Brothers | | | | | |
| | | | | | |
| Sisters | | | | | |
| | | | | | |

Parents: divorced separated remarried married
 Your age when this occurred _____

PERSONAL HISTORY PLEASE ANSWER ALL QUESTIONS.
 (Comment on all positive answers under remarks)

| HAVE YOU HAD? | Yes | No |
|------------------------------------|-----|----|
| Scarlet fever | | |
| Measles | | |
| German measles | | |
| Mumps | | |
| Chicken pox | | |
| Malaria | | |
| Infectious mono. | | |
| Gum or Tooth trouble | | |
| Sinusitis | | |
| Eye trouble | | |
| Ear, Nose, Throat trouble | | |
| Surgery | | |
| Appendectomy | | |
| Tonsillectomy | | |
| Hernia repair | | |
| Other | | |
| Alcohol or substance abuse problem | | |

| HAVE YOU HAD? | Yes | No |
|----------------------------------|-----|----|
| Frequent anxiety | | |
| Frequent depression | | |
| Worry or nervousness | | |
| Recurrent headache | | |
| Recurrent colds | | |
| Head injury with unconsciousness | | |
| Hay fever | | |
| Asthma | | |
| Tuberculosis | | |
| Shortness of breath | | |
| Allergy to: | | |
| Penicillin | | |
| Sulfonamides | | |
| Serum | | |
| Bees, wasps | | |
| Other medicines | | |
| Specify: | | |

| Have any of your relatives ever had any of the following? | Yes | No | Relationship |
|---|-----|----|--------------|
| Alcohol or drug abuse | | | |
| Arthritis | | | |
| Asthma | | | |
| Cancer | | | |
| Depression / Anxiety | | | |
| Diabetes | | | |
| Epilepsy or seizure | | | |
| Heart disease | | | |
| High blood pressure | | | |
| Kidney disease | | | |
| Migraine headaches | | | |
| Nervous or mental disease | | | |
| Suicide attempt | | | |
| Tuberculosis | | | |
| Ulcer or intestinal disease | | | |

| HAVE YOU HAD? | Yes | No |
|--------------------------------------|-----|----|
| Pain/pressure in chest | | |
| Bronchitis | | |
| Chronic Cough | | |
| Palpitations (heart) | | |
| High or low blood pressure (specify) | | |
| Rheumatic fever | | |
| Heart murmur | | |
| Arthritis | | |
| Injury of joints | | |
| "Trick" knee, shoulder, etc. | | |
| Back problems | | |
| Tumor, cancer | | |
| Jaundice - hepatitis | | |
| Stomach or intestinal trouble | | |
| Insomnia | | |

| HAVE YOU HAD? | Yes | No |
|--|-----|----|
| Gall bladder disease | | |
| Diabetes | | |
| Recurrent diarrhea | | |
| Rupture, hernia | | |
| Kidney or bladder disease or infection | | |
| Dizziness, fainting | | |
| Weakness, paralysis | | |
| Sexually transmitted disease | | |
| Albumin/sugar in urine | | |
| Convulsions/seizure | | |
| Eating disorders | | |
| FEMALES ONLY | | |
| Irregular periods | | |
| Severe Cramps | | |
| Excessive flow | | |

| | Yes | No | | Yes | No |
|--|-----|----|---|-----|----|
| A. Has your physical activity been restricted during the past five years? (Give reasons and durations.) | | | E. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years? (Other than routine checkups?) | | |
| B. Have you had difficulty with schools, studies, or teachers? (Give details.) | | | F. Have you been rejected for or discharged from military service because of physical, emotional, or other reasons? (If so, give reasons.) | | |
| C. Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? (Give details.) | | | G. Do you have any questions in regard to your health, family history, or other matters, such as premarital counseling, which you would like to discuss now with a member of the staff in the Health Service? | | |
| D. Have you had any illness or injury or been hospitalized other than already noted? (Give details.) | | | | | |

Will you be participating on a WU Intercollegiate athletic team / cheerleading? yes no Which sport? _____

IF YES, COMPLETE SECTIONS A & B

REMARKS OR ADDITIONAL INFORMATION: _____

Student's Signature _____ Date _____

REPORT OF HEALTH EVALUATION

TO THE EXAMINING PHYSICIAN: Please review the student's history and complete the physician's form. Please comment on all positive answers. THIS STUDENT HAS BEEN ACCEPTED. The information supplied will not affect his/ her status: it will be used only as a background for providing health care, if this is necessary. This information is strictly for the use of the Health Service and will not be released without student consent. Thank you for your cooperation in completing this form. IMMUNIZATIONS ON PAGE 4 ARE REQUIRED BY N.C. LAW.

| SECTION A | SECTION B | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|-----------------------------------|----------|----|--------------------------------|--|--|----------------|--|--|-------------------|--|--|---------------------|--|--|-----------|--|--|---------|--|--|------------------|--|--|--------------------|--|--|--------------------------|--|--|----------------------|--|--|----------|--|--|--|--|--|--|--|-------------------|--------|----------|--------------|--|--|----------|--|--|--------------|--|--|--------|--|--|-------------------|--|--|--------------|--|--|-----------|--|--|--------|--|--|-------|--|--|----------------|--|--|--------|--|--|-----------------|--|--|-----------------|--|--|-----------------|--|--|--------------|--|--|------------------|--|--|---------------------------|--|--|------|--|--|-----------|--|--|--------|--|--|-------|--|--|-------|--|--|--------|--|--|------|--|--|------------|--|--|----------------|-------|------|
| Uncorrected Vision _____ Height _____ inches Weight _____ lbs. Right 20/ _____ Left 20/ _____ Corrected Vision _____ BP _____/_____ Right 20/ _____ Left 20/ _____ Pulse _____ | <h2 style="margin: 0;">SPORT</h2> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are these systems functioning properly? Describe fully. <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:70%;">GENERAL PHYSICAL</th> <th style="width:15%;">Yes</th> <th style="width:15%;">No</th> </tr> </thead> <tbody> <tr><td>1. Head, Ears, Nose, or Throat</td><td></td><td></td></tr> <tr><td>2. Respiratory</td><td></td><td></td></tr> <tr><td>3. Cardiovascular</td><td></td><td></td></tr> <tr><td>4. Gastrointestinal</td><td></td><td></td></tr> <tr><td>5. Hernia</td><td></td><td></td></tr> <tr><td>6. Eyes</td><td></td><td></td></tr> <tr><td>7. Genitourinary</td><td></td><td></td></tr> <tr><td>8. Musculoskeletal</td><td></td><td></td></tr> <tr><td>9. Metabolic / Endocrine</td><td></td><td></td></tr> <tr><td>10. Neuropsychiatric</td><td></td><td></td></tr> <tr><td>11. Skin</td><td></td><td></td></tr> <tr><td>12. Is there loss or seriously impaired function of any organ?</td><td></td><td></td></tr> </tbody> </table> | GENERAL PHYSICAL | Yes | No | 1. Head, Ears, Nose, or Throat | | | 2. Respiratory | | | 3. Cardiovascular | | | 4. Gastrointestinal | | | 5. Hernia | | | 6. Eyes | | | 7. Genitourinary | | | 8. Musculoskeletal | | | 9. Metabolic / Endocrine | | | 10. Neuropsychiatric | | | 11. Skin | | | 12. Is there loss or seriously impaired function of any organ? | | | <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:70%;">B SPORTS PHYSICAL</th> <th style="width:15%;">Normal</th> <th style="width:15%;">Abnormal</th> </tr> </thead> <tbody> <tr><td>Heart/Lungs:</td><td></td><td></td></tr> <tr><td>Max Imp.</td><td></td><td></td></tr> <tr><td>Sinus Rhythm</td><td></td><td></td></tr> <tr><td>Murmur</td><td></td><td></td></tr> <tr><td>Peripheral Pulses</td><td></td><td></td></tr> <tr><td>Breath Signs</td><td></td><td></td></tr> <tr><td>Eye Exam:</td><td></td><td></td></tr> <tr><td>Pupils</td><td></td><td></td></tr> <tr><td>Fundi</td><td></td><td></td></tr> <tr><td>Ocular Muscles</td><td></td><td></td></tr> <tr><td>Vision</td><td></td><td></td></tr> <tr><td>Abdominal Exam:</td><td></td><td></td></tr> <tr><td>Wall herniation</td><td></td><td></td></tr> <tr><td>Testicular Exam</td><td></td><td></td></tr> <tr><td>Liver/Spleen</td><td></td><td></td></tr> <tr><td>Orthopedic Exam:</td><td></td><td></td></tr> <tr><td>Muscle-Strength (General)</td><td></td><td></td></tr> <tr><td>Neck</td><td></td><td></td></tr> <tr><td>Shoulders</td><td></td><td></td></tr> <tr><td>Elbows</td><td></td><td></td></tr> <tr><td>Hands</td><td></td><td></td></tr> <tr><td>Knees</td><td></td><td></td></tr> <tr><td>Ankles</td><td></td><td></td></tr> <tr><td>Feet</td><td></td><td></td></tr> <tr><td>Back/Spine</td><td></td><td></td></tr> <tr> <td>Hand Dominance</td> <td style="text-align: center;">Right</td> <td style="text-align: center;">Left</td> </tr> </tbody> </table> | | B SPORTS PHYSICAL | Normal | Abnormal | Heart/Lungs: | | | Max Imp. | | | Sinus Rhythm | | | Murmur | | | Peripheral Pulses | | | Breath Signs | | | Eye Exam: | | | Pupils | | | Fundi | | | Ocular Muscles | | | Vision | | | Abdominal Exam: | | | Wall herniation | | | Testicular Exam | | | Liver/Spleen | | | Orthopedic Exam: | | | Muscle-Strength (General) | | | Neck | | | Shoulders | | | Elbows | | | Hands | | | Knees | | | Ankles | | | Feet | | | Back/Spine | | | Hand Dominance | Right | Left |
| GENERAL PHYSICAL | Yes | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Head, Ears, Nose, or Throat | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. Respiratory | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. Cardiovascular | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. Gastrointestinal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. Hernia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. Eyes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. Genitourinary | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. Musculoskeletal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9. Metabolic / Endocrine | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. Neuropsychiatric | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. Skin | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 12. Is there loss or seriously impaired function of any organ? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| B SPORTS PHYSICAL | Normal | Abnormal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Heart/Lungs: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Max Imp. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sinus Rhythm | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Murmur | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Peripheral Pulses | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Breath Signs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Eye Exam: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pupils | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fundi | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ocular Muscles | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Vision | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Abdominal Exam: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Wall herniation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Testicular Exam | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Liver/Spleen | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Orthopedic Exam: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Muscle-Strength (General) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Neck | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Shoulders | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Elbows | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hands | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Knees | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ankles | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Feet | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Back/Spine | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hand Dominance | Right | Left | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| REQUIRED PROCEDURES: URINALYSIS: Date _____ Sugar _____ Albumin _____ Micro. _____ HEMOGLOBIN or HEMATOCRIT _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

ALL STUDENTS: HAVE PHYSICIAN COMPLETE SECTION A. STUDENTS IN INTERCOLLEGIATE SPORTS/CHEERLEADING, HAVE PHYSICIAN COMPLETE SECTIONS A & B. Recommendations for physical activity (PE, Intramurals, ROTC) (EXPLAIN) Limited Unlimited

Do you have any recommendations regarding the care of this student? Yes _____ No _____ (EXPLAIN)

Is the patient now under treatment for any medical or emotional condition? Yes _____ No _____

Does student take any medication regularly? Yes _____ No _____ Name _____ Dosage _____

Have you any general comments? Yes _____ No _____

Does this student have a condition requiring special housing considerations? Yes _____ No _____

Please document thoroughly. _____

PLEASE NOTIFY US OF ANY MEDICAL PROBLEMS THAT DEVELOP AFTER THIS EXAMINATION.

I certify that this student has been examined and on the basis of this exam, is medically able to participate in Intercollegiate athletic activities. Yes No Not Applicable

Signature of physician _____

Please print physician's name here _____

Address _____

Business Phone _____ Date _____

Are you the family physician or pediatrician? Yes No If "no," how long have you know student? _____

IMMUNIZATION RECORD (Please print in black ink) To be completed and signed by physician or clinic
 A complete immunization record from a physician or clinic may be attached to this form

| Last Name | First Name | Middle Name | Date of Birth (mo./day/year) | *Social Security Number | | |
|---|------------|----------------------------|------------------------------|-------------------------|---------------------------------|-------------------------|
| SECTION A REQUIRED IMMUNIZATIONS | | | mo./day/year | mo./day/year | mo./day/year | mo./day/year |
| • DTP or Td (3 doses) | | | (#1) | (#2) | (#3) | (#4) |
| • Td Booster (within last 10 years) | | | | | | |
| • Polio (3 doses) | | | | | | |
| • MMR (after first birthday) (2 doses) | | | | | | |
| OR | | | | | | |
| • Measles (after first birthday) (2 doses) | | | | | **Disease Date | ****Titer Date & Result |
| • Mumps (2 doses) | | | | | *** (Disease Date NOT Accepted) | ****Titer Date & Result |
| • Rubella (1 dose) | | | | | *** (Disease Date NOT Accepted) | ****Titer Date & Result |
| • Tuberculin (PPD) Test required within the last 12 months | | Date read mm induration | | | | |
| Chest x-ray, if positive PPD | | Date Results | | | | |
| Treatment, if applicable | | Date | | | | |

SECTION B RECOMMENDED IMMUNIZATIONS

The following immunizations are recommended for all students and may be required by certain colleges or departments (for example, health sciences). Please consult your college or department materials for specific requires.

| | mo./day/year | mo./day/year | mo./day/year | |
|---|--------------|--------------|--------------|-------------------------|
| • Hepatitis B series (3 doses) (required for Pharmacy and PA program) | | | | ****Titer Date & Result |
| • Varicella (chicken pox) (2 doses) or immunity by positive blood filter (required for Pharmacy + PA program) | | | Disease Date | ****Titer Date & Result |
| • Meningococcal | | | | |

Signature or Clinic Stamp REQUIRED:

 Signature of Physician/Physician Assistant/Nurse Practitioner Date

 Print Name of Physician/Physician Assistant/Nurse Practitioner Area Code/Phone Number

 Office Address City State Zip Code

- * Provision of Social Security number is voluntary, is requested solely for administrative convenience and recordkeeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.
- ** Must repeat Rubeola (measles) vaccine if received even one day prior to 12 months of age. History of physician diagnosed measles disease is acceptable, but must have signed statement from physician.
- *** Only laboratory proof of immunity to rubella or mumps is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.
- **** Attach lab report.

ATTENTION STUDENT ATHLETES: If you would like a copy of you Health Info Summary sent to the athletic department, please sign and date the statement below. I give Wingate University Student Health permission to release a copy of my medical information to the athletic department.

 Name Date