

MACALESTER COLLEGE – HEALTH SERVICES

1600 Grand Avenue, Saint Paul, Minnesota 55105

Phone: 651.696.6275 – FAX: 651.696.6687

Email : healthservices@macalester.edu

**Form must be completed
and returned by mail, fax or
e-mail before August 1st.**

HEALTH HISTORY RECORD

(The information contained in this form is CONFIDENTIAL and for the use of Health Services ONLY and for varsity or club athletes, Macalester Sports Medicine staff.) Complete pages 1 and 2 before going to your physician for examination.)

I. STUDENT'S REPORT OF MEDICAL HISTORY....(PLEASE PRINT)

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Last Name	First Name	Middle	Sex	Date of Birth
Home Address (Number and Street)	City or Town	State	Country	Zip
Next of Kin: Name	Relationship	Day Phone	Eve. Phone	Cell Phone
Name of person to call in case of emergency :	Relationship	Day Phone	Eve. Phone	Cell Phone

FAMILY HISTORY

				HAVE ANY OF YOUR BIOLOGICAL RELATIVES (mother, father, grandmother, grandfather, sister, brother) EVER HAD ANY OF THE FOLLOWING?			
	Current Age	Check If Deceased	Age and Cause of Death	Yes	No	Relationship	
Father							
Mother							
Siblings:							

PERSONAL HISTORY

PLEASE CHECK (✓) IF YOU HAVE HAD ANY OF THE FOLLOWING DISEASES OR CONDITIONS.

	YES		YES		YES
Chicken Pox		Hay fever		SURGERY	
German Measles		Head injury w/unconsciousness		Appendectomy	
Measles		Hepatitis/Type		Hernia repair	
Mumps		Hernia		Tonsillectomy	
		High or low blood pressure		Other: List	
		Kidney disease/injury			
ADD/ADHD		Malaria			
Anemia		Mononucleosis		ALLERGIES	
Anorexia/Bulimia		Pain/pressure in chest		Penicillin	
Arthritis		Palpitations		Sulfa	
Asthma		Paralysis		Other medications: List	
Back problems/Scoliosis		Protein/sugar in urine			
Chronic cough		Recent loss/gain of weight			
Convulsions		Recurrent diarrhea/constipation		Foods: List	
Diabetes		Rheumatic fever or heart murmur		Peanut	
Disease or injury of joints		Sexually transmitted disease			
Dizziness or fainting		Shortness of breath		FEMALES ONLY	
Do you smoke? How much?		Sinusitis		Irregular periods	
Ear, nose, throat trouble		Stomach problems		Severe cramps	
Eye problems		Tuberculosis		Excessive flow	
Frequent urination		Tumor, cyst or cancer		Mother took DES	

PERSONAL HISTORY, continued:

PLEASE ELABORATE ON ANY POSITIVE ANSWERS WITH ADDITIONAL COMMENTS IN THE SPACE PROVIDED BELOW.
ALL ANSWERS ARE CONFIDENTIAL.

A. List any illness, injury, surgery, or hospitalization (give dates and explain).

B. Do you take medication routinely? Reason and Type: Yes No

C. Do you have any dietary restrictions or food allergies? Yes No

D. Have you ever been diagnosed and/or treated for an eating disorder (anorexia nervosa, bulimia nervosa, or other)? Yes No

E. Have you ever been involved in counseling or psychiatric therapy for mental illness, personality disorder, family situation, or emotional problem? Yes No

F. Have you been treated for chemical dependency? Type ? Duration of treatment program ? Yes No

Please read and sign below before participation in any athletic activity.

In order for you to participate in varsity and club sports while you attend Macalester, Health Services will release this health information to Athletic Department personnel to determine that you are approved to participate in these activities.

I authorize Health Services to provide the Macalester Sports Medicine staff this health history, exam, and immunization records. This may be done with my consent.

Student's Signature

Birthdate

Date

If you are under 18 please have your parent/guardian sign below. Students under 18 years of age must have parental permission to receive medical treatment or emergency care through our Health Services. I give permission for my son/daughter to receive medical treatment or emergency care through Health Services.

Parent/Guardian Signature

Date

III. IMMUNIZATION and TUBERCULIN SKIN TEST RECORD

Macalester College and the State of Minnesota REQUIRE PROOF that you have had the following immunizations. You will not be able to attend classes until Health Services has proof that you are in compliance with these requirements.

STUDENT'S NAME _____ BIRTHDATE _____

THIS FORM MUST BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER
(Dates must include month, day, and year. *All information must be in English*)

A. TUBERCULIN SKIN TEST (REQUIRED)

We will be doing this test on you once you arrive on campus for a charge that will be billed to your Student Account.

B. TETANUS-DIPHTHERIA (REQUIRED) (Primary series with DTP and booster with Td in the last 10 years)

1. Primary Series of 4 doses DTP #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___
Mo Day Yr Mo Day Yr Mo Day Yr Mo Day Yr
2. Tetanus-Diphtheria Booster (Td or TdaP) within the last 10 years..... ___/___/___
Mo Day Yr

C. M.M.R. (MEASLES, MUMPS, RUBELLA) (REQUIRED)

1. Dose 1 – immunized at 15 months of age or later..... ___/___/___
Mo Day Yr
2. Dose 2 – immunized at 5 years of age or later..... ___/___/___
Mo Day Yr

Or Separate Immunizations:

- MEASLES (Rubeola or hard measles) Dose #1 given at 15 months or later.....#1 ___/___/___ #2 ___/___/___
Mo Day Yr Mo Day Yr
- MUMPS Dose #1 given at 15 months or later.....#1 ___/___/___ #2 ___/___/___
Mo Day Yr Mo Day Yr
- RUBELLA (Three Day or German Measles) Dose #1 given at 15 months or later..... #1 ___/___/___ #2 ___/___/___
Mo Day Yr Mo Day Yr

HEALTH CARE PROVIDER SIGNATURE (REQUIRED)

Name: _____ Office Phone: _____

Signature of Health Care Provider _____ Office FAX: _____

The following immunizations are RECOMMENDED, but not required.

D. VARICELLA (Chicken Pox)

Two doses of vaccine given at least one month apart if no history of having chicken pox.

1. History of disease Yes No
2. Varicella antibody test ___/___ Reactive (+) Non Reactive (-)
Mo Yr
3. Varivax immunization Dose #1 ___/___/___ Dose #2 (given at least one month after 1st dose) ___/___/___
Mo Day Yr Mo Day Yr

E. HEPATITIS B Three doses of vaccine or positive surface antibody test

1. Hepatitis vaccination #1 ___/___/___ #2 ___/___/___ #3 ___/___/___
Mo Day Yr Mo Day Yr Mo Day Yr
- OR**
2. Hepatitis B Surface Antibody Result: Reactive (+) Non Reactive (-) Test Date: ___/___/___
Mo Day Yr

F. MENINGOCOCCAL VACCINE (Menomune or Menactra) Recommended by American College Health Association

for students living in dorms, or any student under age 25..... dose ___/___/___
Mo Day Yr

G. HPV Vaccine (Gardasil) – Recommended for females <26 years old for prevention of cervical cancer and genital warts.

#1 ___/___/___ #2 ___/___/___ #3 ___/___/___
Mo Day Yr Mo Day Yr Mo Day Yr

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