

PERSONAL HISTORY, continued:

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

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- A. List any illness, injury, surgery, or hospitalization (give dates and explain).
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- B. Do you take medication routinely? Reason and Type: Yes No
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- C. Do you have any dietary restrictions or food allergies? Yes No
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- 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, the Health & Wellness Center must indicate to the Athletic Department personnel that you are approved to participate in these activities; and share with them a copy of your current physical and immunization records. (this does not include your health history record)

I authorize the Health & Wellness Center to indicate to the Athletic Department whether or not I am approved by my physician to participate in sports activities and to release a copy of my current physical examination and immunization records. This may be shared 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 & Wellness Center. I give permission for my son/daughter to receive medical treatment or emergency care through the Health & Wellness Center.

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 & Wellness Center 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. TUBERCULOSIS SKIN TEST (PPD-mantoux) - REQUIRED within the last 3 months—Regardless of prior BCG inoculation

- 1. PPD (Mantoux 0.1 ml of 5TU) **Tine or monovac not acceptable**
Date Given: ___/___/___ Date Read: ___/___/___ **Must be recorded in mm – required by MN**
Mo Day Yr Mo Day Yr Result: _____ mm
- 2. If PPD is >5 mm, current chest x-ray results required. **Enclose copy of written CXR results-NO FILMS** Date of x-ray: ___/___/___
Mo Day Yr Mo Day Yr
- 3. Therapy for + (positive) PPD – send documentation INH x _____ months or Rifampin

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) within the last 10 years..... ___/___/___
Mo Day Yr
- And/Or:
- 3. Tdap Booster 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..... Menactra Menomune 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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