AURORA UNIVERSITY
Wellness Center
347 S. Gladstone Ave., Aurora, IL 60506-4892

Certificate of Health Examination and Immunity

(Please return to Wellness Center before July 15 for fall semester enrollment and Dec. 1 for spring semester enrollment)

Name:_____ **Date of Birth:**____/____/____ **Sex:** ❒ M ❒ F **SS#:**_____
(Last / First / Middle) Month / Day / Year

Permanent Address:_____ **Phone Number:**_____
(Street/Apartment Number)

_____ **Country:**_____
(City / State / ZIP)

Do you plan to live on campus? ❒ Yes ❒ No **Campus Phone Number:**_____

Parent/Guardian:_____ _____ _____ _____
(Name) (Relationship) (Home Phone) (Work Phone)

_____ _____ _____ _____
(Name) (Relationship) (Home Phone) (Work Phone)

In case of emergency, notify:_____

Semester and year of enrollment: ❒ Fall____ ❒ Spring ____ ❒ Summer ____

Class Standing: FR / SO / JR / SR / 5th / Graduate Student _____ (year) **Will you be attending:** ❒ Full-time ❒ Part-time

Have you previously attended Aurora University? ❒ No ❒ Yes - If yes, please indicate year(s)_____

Are you an AU athlete? ❒ No ❒ Yes – If yes, **please indicate which sport(s):** _____

Have you had: *

	NO	YES		NO	YES		NO	YES
Allergies (seasonal)			Respiratory problems			Rheumatic fever		
Head injury			Tuberculosis			High blood pressure		
Dizziness/fainting			Gastrointestinal problems			Low blood pressure		
Dizziness/fainting with exertion			Loss of paired organ function			Heat related illness (exhaustion/stroke)		
Headaches (migraines)			Recent weight changes			Hernia		
Seizure disorder			Gallbladder problems			Kidney/urinary problems		
Meningitis			Stomach ulcers			Anemia		
Ear problems (hearing loss)			Diabetes Mellitus (Type I/II)			Blood disorders		
Eye problems			Low blood sugar			Cancer		
Sinus problems			Liver disease			Chicken pox		
Strep throat (recurrent)			Hepatitis A, B, C			Fracture/sprain		
Thyroid problems			Mononucleosis			Back problems		
Frequent colds			Heart murmur			Marfan's Syndrome		
Asthma (chronic)			Heart arrhythmia			Eating disorders		
Asthma (exercise induced)			Heart disease			Counseling/mental health treatment		

Orthopedic Injuries: *

	NO	YES		NO	YES
Ankle		R L	Elbow/arm		R L
Shin Splints		R L	Wrist/hand		R L
Knee		R L	Neck		R L
Hip		R L	Head		
Back			Concussion/loss of consciousness		
Shoulder		R L	Internal		

Please explain all answers marked with *YES:

_____

_____

I HEREBY CERTIFY THAT THE ABOVE QUESTIONS ARE ANSWERED TO THE BEST OF MY KNOWLEDGE.

Student Signature:_____ Date:_____

Health History: Please answer all of the following questions. **Page 2**

1. **Do you have any allergies?** ***(medications, foods, environmental, insect bites/stings):*** ❒ No ❒ Yes (explain below)

Allergen	Reaction

2. **Are you currently under the supervision of a physician?** ❒ No ❒ Yes (please explain below)
If yes, please explain:_____

3. **Are you currently taking any medications?** ❒ No ❒ Yes (please list below)
Please include medications taken on a regular or as-needed basis along with any vitamins, herbal or nutritional supplements.

Medication (name, dose, frequency)*	Reason
**If you administer injectable prescription medications, contact the Wellness Center to receive information on disposal of syringes and needles.*	

4. **Have you ever been hospitalized (injury or illness) or had any surgical procedures?** ❒ No ❒ Yes (please list below)

Reason	Dates

5. **Have you ever been diagnosed with a stress fracture?** ❒ No ❒ Yes (please provide details below)

Location	Date

6. **Do you have a family history of the following?**

Disease	No	Yes	If yes, please indicate relationship
Diabetes			
Cancer			
Heart disease			
Hypertension			
Tuberculosis			
Stroke			

****Has any member of your family died suddenly before the age of 40 from a non-traumatic cause?***
❒ No ❒ Yes - If yes, please explain how: _____

7. **Please complete the appropriate section:**

For Women	For Men
Onset first menstrual period (age):	Testicular conditions ❒ No ❒ Yes **Explain:**
Abnormal flow? ❒ No ❒ Yes **Explain:**	
Excessive/severe cramping? ❒ No ❒ Yes	Prostate conditions ❒ No ❒ Yes **Explain:**
Pregnant now or within past year? ❒ No ❒ Yes	
Date of last pelvic exam**:**	

8. **Is there anything we should know about your health that we have not asked yet?** ❒ No ❒ Yes
If yes, please explain:_____

I HEREBY CERTIFY THAT THE ABOVE QUESTIONS ARE ANSWERED TO THE BEST OF MY KNOWLEDGE.

Student Signature:_____ Date:_____

Physical Examination: To be completed by a physician — Page 3

TO THE EXAMINING PHYSICIAN: Please review the student's history, complete the physical examination and immunization history and comment on all positive answers (also complete and sign page 4).

******A physician signature is required for the physical examination and immunization history sections.******

Student's Name: Date of Birth:

Required Measurements				Strongly Recommended Tests	
Height	**Weight**	**B/P**	**Pulse**	**Urinalysis (dipstick)** Alb._____ Sug._____	**Hemoglobin or Hematocrit** _____ gms/% _____%

Clinical Evaluation:	Normal	Abnormal	Comments
Skin			
Eyes, ears, nose, sinuses			
Mouth/dental			
Throat			
Heart (murmurs, size, sounds)			
Respiratory system			
Gastrointestinal system			
Genital-urinary system			
Neurological status			
Musculoskeletal system			
Spinal examination			
Nutritional status **Please list any dietary restrictions*			
Mental health			
Other *(general comments)*			

Orthopedic Exam: ❒Normal ❒ Abnormal
(Please explain all abnormalities or orthopedic concerns)

Recommendations for physical activity in physical education, intercollegiate, or club sports (select one):

❒ There are ***no restrictions*** for participation of the above named student in intercollegiate athletics, physical education or club sports.

❒ The above-named student ***may participate only after*** the following steps have been taken to ensure good health.
(Please explain): _____

❒ The above-named student ***may not participate*** in intercollegiate athletics, physical education or club sports.
(Please explain):_____

Physician Verification of Physical Exam (Required):

Physician Name:_____ Date of Exam:_____

Address:_____

Phone Number (with area code) :_____Signature:_____

Office Stamp:

Immunization History: To be completed by physician

Student's Name:_____ **Date of Birth:**_____

MMR (measles, mumps, rubella)*
Two doses required, at least one month apart, and after 12 months of age and after live vaccine available (5-1-71) #1____/____/____ (month / day / year) #2____/____/____ (month / day / year)

***IF MMR WAS NOT GIVEN, INDIVIDUAL IMMUNIZATIONS SHOULD BE LISTED BELOW**

MEASLES (Rubeola, Hard, Red, 10 day)

❒ 1. Two doses required at least one month apart, after 12 months of age and after (1-1-68) #1____/____/____ (month / day / year) #2____/____/____ (month / day / year)

OR ❒ 2. Date disease diagnosed and certified by physician ____/____/____ **Attach letter from physician (MD or DO)**

OR ❒ 3. Lab test proving immunity ____/____/____ **Attach lab report**

RUBELLA (German measles, 3 day)

❒ 1. One dose required after 12 months of age and after (6-19-69) ____/____/____ (month / day / year)

OR ❒ 2. Lab test proving immunity ____/____/____ **Attach lab report**

MUMPS

❒ 1. One dose required after 12 months of age and after (1-1-68) ____/____/____ (month / day / year)

OR ❒ 2. Date disease diagnosed and certified by physician ____/____/____ **Attach letter from physician (MD or DO)**

OR ❒ 3. Lab test proving immunity ____/____/____ **Attach lab report**

DIPHTHERIA, PERTUSSIS, TETANUS, TETANUS/DIPHTHERIA

#1____/____/____ (month / day / year) #2____/____/____ (month / day / year) #3____/____/____ (month / day / year) #4____/____/____ (month / day / year)

Latest Booster:

____/____/____ (month / day / year)
Please indicate: ❒ Td ❒ Tdap
(must be within past 10 years)

Recommended Immunizations
*** The following immunizations are highly recommended but not required unless specified by your major***
Athletic Training and Nursing Majors require additional immunizations:
Nursing majors: Hepatitis B series, Two-Step Tuberculosis Skin Testing and Results, and proof of immunity to Varicella.
Athletic training majors: Hepatitis B series

HEPATITIS B (3 doses of vaccine):

1st: ____/____/____ (month / day / year) **2nd:** ____/____/____ (month / day / year) **3rd:** ____/____/____ (month / day / year)

INFLUENZA:

____/____/____ (month / day / year)
Annual immunization recommended to avoid disruption to academic activities

VARICELLA (Requirements can be met by one of the following):

❒ Immunization **Dose #1 Date:** ____/____/____ **Dose #2 Date:** ____/____/____

OR ❒ History of Disease Yes / No **Date:** ____/____/____

OR ❒ Varicella antibody Reactive / nonreactive **Date:** ____/____/____

MENINGOCOCCAL TETRAVALENT (A,C,Y, W-135):

❒ **Tetravalent conjugate:** ____/____/____ (Preferred; data for revaccination pending) **OR** ❒ **Tetravalent polysaccharide** ____/____/____ (Acceptable alternative if conjugate not available, revaccinate every 3-5 years if at risk)

TUBERCULOSIS SKIN TEST:
Date Given: ____/____/____ **Date Read:** ____/____/____ **Results:** Negative / Positive **- If positive, Chest X-ray required;**
Date ____/____/____ **Chest X-ray results:** Normal / Abnormal

****Nursing Students Only****
PPD one-step given on ____/____/____, read on ____/____/____ **Results:** Negative / Positive **Signature:**_____
PPD two-step given on ____/____/____, read on ____/____/____ **Results:** Negative / Positive **Signature:**_____

Physician Verification of Immunization History (Required):

Physician Name:_____ Phone number:_____

Address:_____

Signature:_____ Date:_____

Office Stamp:

For Office Use Only

Complete: **Reviewed by:** **Date:** **Entered into Computer:** **Exemptions:** Medical Religious Age Allergy