KANSAS WESLEYAN UNIVERSITY
100 East Claflin Avenue
Salina, Kansas 67401-6196
785-827-5541
1-800-874-1154
FAX 785-404-1485

Date of Exam: ______________________ Sport: ______________________
(If Applicable)

Current Year: **FR** **SO** **JR** **SR** Student ID: ______________________
(circle one)

Physical Examination Record

To Be Completed By All Full-Time Students

Name ______________________________ Date of Birth ______________
Social Security Number ______________________________ Local/Cell Phone ______________
Campus/Local Address ____
Street City State Zip Code

Parent's Name ______________________________ Phone ( ) ______________
Home/Permanent Address ____
Street City State Zip Code

Insurance and Parent Contact Information

Must Be Completed

Head of Household ______________________________ Date of Birth ______________
Employer Name ______________________________ Phone ( ) ______________
Insurance Co. Name ______________________________ Identification # ______________
Insurance Co. Phone ______________________________ Is Student Insured _____Yes _____No

Other Parent/Spouse ______________________________ Date of Birth ______________
Employer Name ______________________________ Phone ( ) ______________
Insurance Co. Name ______________________________ Identification # ______________
Insurance Co. Phone ______________________________ Is Student Insured _____Yes _____No

Please attach a copy of your Insurance Card

Please answer the following if your parents' or spouse's insurance does not cover you and you have your own insurance plan:

Name of Individual ______________________________ Date of Birth ______________
Employer Name ______________________________ Phone ( ) ______________
Insurance Co. Name ______________________________ Identification # ______________
Insurance Co. Phone ______________________________

Please attach a copy of your Insurance Card

If you <u>DO NOT</u> have any type of insurance coverage, please sign and date below.

Signature ______________________________ Date ______________

Continued on next page.

Medical History Information

Circle Yes or No, if Yes please explain.

General Medical

Question		
1. Have you been advised by a physician in the past five years to restrict activity?	Yes	No
2. Do you have any chronic illness requiring regular medical visits or follow up?	Yes	No
3. Have you ever had surgery?	Yes	No
4. Are you currently taking any medications? (Over the Counter or Prescription)	Yes	No
5. Are you missing any paired organs? (i.e. kidney, lung, testical)	Yes	No
6. Do you have any allergies? (i.e. medication, seasonal, bee stings, pollen)	Yes	No
7. Have you ever been diagnosed with Diabetes?	Yes	No

Explain any **Yes** answers above. ______________________________

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Cardiac

Question		
1. Have you ever had chest pain during exercise?	Yes	No
2. Have you ever passed out during exercise?	Yes	No
3. Have you ever been dizzy during exercise?	Yes	No
4. Have you every had high blood pressure?	Yes	No
5. Have you ever been told that you have a heart murmur?	Yes	No
6. Have you ever had racing of your heart, or skipped beats?	Yes	No
7. Does your family have a history of Marfan's Syndrome, or an abnormally thickened heart?	Yes	No
8. Has anyone in your family died of heart problems or a sudden death before age 50?	Yes	No

Explain any **Yes** answers above. ______________________________

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Neurological

Question		
1. Have you ever had a head injury?	Yes	No
2. Have you ever been diagnosed with a concussion?	Yes	No
If Yes How many? __________		
3. Have you ever been knocked out or unconscious?	Yes	No
4. Have you ever had a seizure?	Yes	No
5. Have you ever had a "stinger, " "burner," or pinched nerve?	Yes	No
6. Do you have frequent headaches?	Yes	No

Explain any **Yes** answers above. ______________________________

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Heat Illness

Question		
1. Have you ever been diagnosed with a Heat Illness?	Yes	No
2. Have you ever had heat or muscle cramps?	Yes	No
3. Have you every been dizzy, nauseous, or passed out in the heat?	Yes	No

Explain any **Yes** answers above. ______________________________

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Pulmonary

Question		
1. Do you have any history of asthma or exercise induced asthma?	Yes	No
2. Do you have any trouble breathing, or do you cough during or after activity?	Yes	No

Explain any **Yes** answers above. ______________________________

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Continued on next page.

Medical History Information (cont.)

Circle Yes or No, if Yes please explain.

Vision

1. Do you have problems with your eyes or vision?	Yes	No
2. Do you wear glasses, contacts, or protective eye wear?	Yes	No
3. Have you seen an eye doctor in the last year?	Yes	No

Explain any **Yes** answers above. ______________________________

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Blood

1. Do you have a history of anemia or a blood clotting disorder?	Yes	No
2. Have you ever been diagnosed with mononucleosis (Mono)?	Yes	No
3. Have you ever been diagnosed with any other blood disorder?	Yes	No

Explain any **Yes** answers above. ______________________________

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Nutrition

1. Do you regularly use any nutritional supplements? (i.e. creatine, vitamins)	Yes	No
2. Have you ever used illegal drugs?	Yes	No
3. Have you ever been diagnosed with disorder eating, anorexia, bulimia?	Yes	No

Explain any **Yes** answers above. ______________________________

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Males Only

1. Do you have any problem with your testicles?	Yes	No

Explain any **Yes** answers above. ______________________________

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Females Only

1. When was your last menstraul period? ______________________________
2. How many menstraul cycles have you had in the last 12 months? ______________________________

Orthopedic

Have you ever sprained, strained, dislocated, fractured/broken, or had injury to any of the following:

Head	____________	Hip	____________
Neck	____________	Knee	____________
Back	____________	Ankle	____________
Shoulder	____________	Shin	____________
Elbow	____________	Foot	____________
Hand/Wrist	____________	Chest/Ribs	____________

Please list any injuries and/or surgeries and the date with Doctor's Name.

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Continued on next page.

Medical History Information (cont.)

Circle Yes or No, if Yes please explain.

Other

1. Do you have any problems with your teeth?	Yes	No
2. Do you have any current skin disorders?	Yes	No
3. Have you ever been diagnosed with a Staph infection or MRSA?	Yes	No

Explain any **Yes** answers above. ______________________________

Immunization Record

It is important to your personal health, as well as the Kansas Wesleyan Univeristy community health, that your immunizations are complete and up-to-date. The following persons are exempt from needing to show documented evidence of immunizations:

__________ 1. I have a physical condition such that an immunization would endanger life or health.
__________ 2. I adhere to a religion/personal belief whose teachings are opposed to immunizations.

For all other persons, not exempt above, please provide the following information. If you have reason to think you are not current in these immunizations, see your physician or local Public Health Department for updated immunizations.

Immunization	Date of Immunization	Date of Booster
Measles (Rubeola)	________	____________
German Measles (Rubella)	________	____________
Mumps	________	____________
MMR (Mumps/Measles/Rubella)	________	____________
Tetanus or TD (Tetanus/Diphtheria)	________	____________
DPT (Diphtheria/Pertusis/Tetanus)	________	____________
Polio	________	____________
Hepatitis B 1 ______ 2 ______	3 ________	

Tuberculosis (Positive test for TB or any known exposure to Tuberculosis)
Positive Test Date ________ Therapy/Medications ____________

Meningococcal Meningitis Vaccine ***(Required)*** Date ____________
(Or see Waiver on Page 5) Type ____________
(Menactra/Menomune)

For information on Meningitis visit http://www.cdc.gov/ncidod/diseases/submenus/sub_meningitis.htm

I certify that the above information provided by me is true and correct. I understand that if I knowingly misrepresent or falsify essential information requested by this form I may, upon conviction, be subject to fine or imprisonment.

Signature ______________________________ **Date** ____________

Continued on next page.

Meningococcal Vaccination Waiver

Vaccine Waiver: to be completed by the individual (or parent/guardian for individuals less than 18 years of age) **requesting an exemption from the requirement.**

Section 1A: For students 18 years of age or older:
I am 18 years of age or older. I am aware that meningococcal disease is a rare, but life-threatening illness. I understand that Kansas Wesleyan University policy requires that students residing in the residence halls be vaccinated against meningococcal disease or sign a waiver. I voluntarily agree to release, discharge, indemnify and hold harmless Kansas Wesleyan University, it officers, employees, and agents from any and all costs, liabilities, expenses, claims, or causes of action on account of any loss or personal injury that might result from my decision not to be immunized against meningococcal disease.

Name of Student_____________________________________

Signature of student _________________________________ Date____________________

Section 1B: For students under 18 years of age:
I am the parent/guardian of _______________________________ I acknowledge that the disease is rare but life threatening. I understand that Kansas Wesleyan University policy requires that students residing in the residence halls be vaccinated against meningococcal disease. I voluntarily agree to release, discharge, indemnify and hold harmless Kansas Wesleyan University, its officers, employees and agents from any and all costs, liabilities expenses, claims, demands, or causes of action on account of any loss or personal injury that might result from my decision not to have the above named individual immunized against meningitis.

NAME OF PARENT/GUARDIAN_____________________________________

SIGNATURE OF PARENT/GUARDIAN______________________________ DATE__________________

HIPAA Release

Institution's Authorization for the Use and Disclosure of Information

HIPAA stands for Health Insurance Portability and Accountability Act and was created to increase the privacy of Individuals' personal health information. It affects all those who are in contact with medical records or personal health information. Under this law, certified athletic trainers (ATC's) will no longer be able to speak to anyone in regards to an injury or condition unless a release is signed.

I am allowing **FULL** disclosure of my personal health information in regards to any athletic injury I may sustain while participating in intercollegiate athletics at Kansas Wesleyan University. I understand that by allowing partial or no disclosure of my personal health information I will forfeit my participation in intercollegiate sports at Kansas Wesleyan University.

All of the following individuals may be told about my condition:

Athletic Training Staff | Athletic Director
Coaches | Media
Parents | E.I.I.A
Summit America Insurance Services | Team Physicians and Doctor's Office Staff.

Signature: ___________________________________ **Date:** ______________________

Witness: ___________________________________ **Date:** ______________________

Continued on next page.

Physical Examination

To be Completed by Physician

General Medicine

Height ____________
Weight ____________
Pulse ____________
Blood Pressure (/) (/) (/)

	Normal	**Abnormal Findings**	**Comments**
HEENT			
Heart			
Lungs			
Abdomen			
Genitalia			
Neurologic			

Orthopedic Medicine

	Normal	**Abnormal Findings**	**Comments**
Neck			
Back			
Shoulders			
Elbow			
Wrist			
Hand			
Fingers			
Hips			
Thigh			
Knees			
ACL			
MCL			
LCL			
Lower Leg			
Ankles			
Foot			
Toes			

Additional Comments:

Cleared for participation in collegiate athletics: **Yes** **No**

Doctor's Signature: ______________________________ Date ____________

Printed Doctor's Name or Stamp: ______________________________