Southwestern University

HEALTH RECORD

Southwestern University Health Center strives to provide excellent medical services that promote physical and mental health, support academic success, and foster a healthy campus community. We recognize each student encounter as an opportunity for health promotion and education. We are committed to providing high quality services that are confidential, respectful, accessible, and support the holistic wellness of the individual. The health care team includes a full-time nurse practitioner, a full-time registered nurse, two part-time physicians, 1 part-time physician assistant, and a health educator.

HEALTH RECORD CHECKLIST

- ☐ **Health Record forms:** Two-page form (inside) includes physical exam, TB test & immunization record.
- ☐ **Athlete Medical Clearance form:** (Athletes only) includes sickle cell screening.
- ☐ **Submit completed forms:** Due to the confidential nature of this information, please mail forms directly to the Southwestern University Health Center no later than **June 1** for Fall semester enrollment, or **January 2** for Spring semester enrollment.

Southwestern University
Attn: Health Center
PO Box 770
Georgetown, Texas 78627-0770
P: 512-863-1252

IMPORTANT INFORMATION

Proof of Immunization

Proof of immunizations, or shot record, is a requirement for enrollment to all institutions of higher education in Texas. **All incoming students 21 years of age and under must show proof of a Meningitis vaccination within five (5) years of the first official day of classes.**

A complete immunization record includes your name, date of birth, and dates of all immunizations received throughout your lifetime.

If you are graduating from high school or transferring from a college, your school nurse or health services office may be able to print a copy of your immunization record.

Physical and TB Test

All students are required to have a TB screening test and a physical exam performed by a physician, physician assistant or nurse practitioner. These are required and must be dated within 1 year prior to the first day of classes.

Athlete Medical Clearance and Sickle Cell Screening

The National Collegiate Athletic Association (NCAA) now requires Sickle Cell screening for all participating athletes. If you were born in Texas after 1990, you have already been screened and you may be able to obtain your results from the Texas Department of State Health at 1.888.963.7111 ext 7578.

If you were born outside of Texas, you will need to contact that state's Health Department to see if you were screened, and/or to obtain your results. If you have not been screened, your medical provider can order a blood test for this screening.

Be sure to include the results of your sickle cell screening with your Athlete Medical Clearance information.

Southwestern University

HEALTH RECORD (1 OF 2)

TO BE COMPLETED BY THE STUDENT

This record must be completed fully and returned to the Health Center no later than June 1 for Fall enrollment, or January 2 for Spring enrollment.
Mail to: Southwestern Health Center, P.O. Box 770, Georgetown, TX 78627-0770 or **Fax:** 512-863-1310

1. STUDENT INFORMATION

ENTERING AS: ☐ First-Year / ☐ Transfer | **STATUS:** ☐ Sophmore / ☐ Junior / ☐ Senior

STUDENT'S LAST NAME | FIRST | MIDDLE | PREFERRED NAME

BIRTHDATE (MM/DD/YY) | GENDER | COUNTRY OF CITIZENSHIP | STUDENT'S CELL PHONE

PERMANENT HOME ADDRESS: NUMBER & STREET | CITY | STATE/PROVIDENCE | ZIP/POSTAL

PARENT(S) OR GUARDIAN(S) FULL NAME(S) | RELATIONSHIP TO STUDENT

PARENT HOME ADDRESS: NUMBER & STREET | CITY | STATE/PROVIDENCE | ZIP/POSTAL

PARENT HOME PHONE | PARENT CELL PHONE | PARENT BUSINESS PHONE

EMERGENCY CONTACT NAME | EMERGENCY PHONE | RELATIONSHIP TO STUDENT

2. FAMILY HISTORY: Have any of your family members experienced the following?

☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Kidney Disease ☐ Cancer (type) _____
☐ Suicide ☐ Eating Disorders ☐ Depression ☐ Anxiety ☐ Alcoholism ☐ Substance Abuse

Please describe any significant medical history for each of the following *(attach seperate sheet if needed)*

FATHER

MOTHER

SIBLINGS

3. PERSONAL HISTORY: Please circle Y or N. **If yes to any,** *attach explanation with dates & information.*

Y or N — Asthma
Y or N — Cancer
Y or N — Diabetes/ Pre-diabetes
Y or N — Heart Disease
Y or N — High Blood Pressure
Y or N — Rheumatic Disease
Y or N — Bone/Joint Disease
Y or N — Kidney/Bladder Disease
Y or N — Gastrointestinal Disease

Y or N — Head Injury
Y or N — Migraines
Y or N — Seizures
Y or N — Fainting
Y or N — Anxiety
Y or N — Depression
Y or N — Psychiatric Treatment
Y or N — Menstrual Problems
Y or N — Other Disabilities/Needs

Y or N — Contact lenses/ Hearing aids
Y or N — Tuberculosis
Y or N — Measles
Y or N — Chicken Pox
Y or N — Infectious Mononucleosis
Y or N — Appendectomy
Y or N — Tonsillectomy
Y or N — Hernia Repair
Y or N — Other Operations

Drug Allergies: _____
_____
_____
_____

Food Allergies: _____
_____

Environmental Allergies: _____
_____

4. HEALTH INSURANCE: Please provide the Health Center with a copy of your private insurance ID card (front & back). Include name and address of primary policy holder, and their relationship to student.

5. PERSONAL HISTORY: Permission is hereby granted to the Southwestern University Health Center to authorize medical and surgical services, including physician ordered injections or required immunizations. In case of emergency, when the student is unconscious, the Health Center is authorized and requested to refer the student to a duly licensed physician or hospital, and such physician or hospital is authorized to administer treatment or surgery as appears prudent under the circumstances then existing.

STUDENT'S SIGNATURE | DATE

Southwestern University

HEALTH RECORD (2 OF 2)

TO BE COMPLETED BY PHYSICIAN

This record must be completed fully and returned to the Health Center no later than June 1 for Fall enrollment, or January 2 for Spring enrollment.
Mail to: Southwestern Health Center, P.O. Box 770, Georgetown, TX 78627-0770 or **Fax:** 512-863-1310

6. PHYSICAL EXAM (SIGNATURE REQUIRED BEFORE SUBMITTING)

STUDENT'S LAST NAME | FIRST | MIDDLE | DATE OF BIRTH (MM/DD/YY) | GENDER

STUDENT VITALS

TEMPERATURE | BLOOD PRESSURE | PULSE | RESPIRATIONS

HEIGHT | WEIGHT | BMI

VISION: | RIGHT | LEFT

CORRECTED VISION: | RIGHT | LEFT

SYSTEMS NORMAL? Please describe any abnormal findings.

☐ Yes ☐ No **Head, Ears, Nose or Throat:**_____

☐ Yes ☐ No **Skin:**_____

☐ Yes ☐ No **Respiratory:**_____

☐ Yes ☐ No **Cardiovascular:** _____

☐ Yes ☐ No **Gastrointestinal:** _____

☐ Yes ☐ No **Eyes:**_____

☐ Yes ☐ No **Musculoskeletal:** _____

☐ Yes ☐ No **Metabolic/Endocrine:** _____

☐ Yes ☐ No **Neurologic:** _____

☐ Yes ☐ No **Psychiatric:** _____

☐ Yes ☐ No **Is patient under medical/psychological treatment:**

_____

☐ Yes ☐ No **Any recommendations regarding care of student:**

_____

TESTS & VACCINATIONS

Tuberculin Skin Test* - PPD (required within 1 yr.)

DATE PLACED | DATE READ | RESULTS (NEGATIVE OR POSITIVE)

IF POSITIVE: CHEST X-RAY RESULTS | MEDICATIONS

*Alternatively, QuantiFERON-TB Gold or T-Spot TB test may be performed. Write (NEGATIVE) or (POSITIVE) and attach results.

Meningococcal Vaccine (required within 5 yrs. for age 21 & under)

VACCINATION DATE

Diphtheria-Tetanus-Acellular Pertussis (within 7 yrs.)

VACCINATION DATE

Polio

VACCINATION DATE

Measles/Mumps/Rubella-MMR (required 2 doses OR immune titer)

VACCINATION DATE 1 | DATE 2 | DATE 3

Hepatitus B

VACCINATION DATE 1 | DATE 2 | DATE 3

HPV/Gardasil

VACCINATION DATE 1 | DATE 2 | DATE 3

PHYSICIAN SIGNATURE:

PHYSCIAN'S NAME (PRINTED) | PHYSICIAN'S SIGNATURE | DATE OF EXAM

PHYSICIAN ADDRESS: STREET & NUMBER | CITY | STATE/PROVIDENCE | ZIP/POSTAL | PHONE

Southwestern University

ATHLETE MEDICAL CLEARANCE

1. TO BE COMPLETED BY THE STUDENT (ATHLETES ONLY)

The Athletic Training Department is now using the **Southwestern University Student Health Record** to serve as the primary health clearance for participation in any intercollegiate athletics program. We are required to have a copy of the physical on file in our office before any individual can participate. Be sure to attach the required Sickle Cell screening results with this form.

STUDENT'S LAST NAME | FIRST | MIDDLE | SPORT(S) PARTICIPATING IN

Student's Informed Consent for Release of Information

I hereby authorize the Southwestern Health Center to release information to Southwestern University athletic trainers and team physicians. I understand that my records are protected by federal law and cannot be disclosed without this written consent unless otherwise provided in federal regulations. I may revoke this consent at any time, except to the extent that action has already been taken. My signature also means I have read this form and understand its contents.

STUDENT'S SIGNATURE | DATE

2. TO BE COMPLETED BY PHYSICIAN (SIGNATURE REQUIRED BEFORE SUBMITTING)

MEDICAL CLEARANCE (initial & enter comments below)

_____ From this evaluation, I have determined that the above patient IS PHYSICALLY ABLE and therefore CLEARED, without any limitation, to participate in the intercollegiate athletics program at Southwestern University.

_____ From this evaluation, I have determined that the above patient NEEDS FOLLOW-UP CARE AND/OR TESTING in order to be cleared to participate in any intercollegiate athletics program at Southwestern University.

_____ From this evaluation, I have determined that the above patient IS NOT PHYSICALLY ABLE at this time and therefore NOT CLEARED to participate in any intercollegiate athletics program at Southwestern University.

SICKLE CELL SCREENING (required, attach results)

DATE READ | RESULTS (NEGATIVE OR POSITIVE)

INJURY HISTORY

YEAR | TYPE & LOCATION

COMMENTS

YEAR | TYPE & LOCATION

COMMENTS

YEAR | TYPE & LOCATION

COMMENTS

YEAR | TYPE & LOCATION

COMMENTS

YEAR | TYPE & LOCATION

COMMENTS

PHYSICIAN SIGNATURE:

PHYSCIAN'S NAME (PRINTED) | PHYSICIAN'S SIGNATURE | DATE OF EXAM

PHYSICIAN ADDRESS: STREET & NUMBERCITY | STATE/PROVIDENCE | ZIP/POSTAL | PHONE