

Allergies & Restrictions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HUNTINGTON UNIVERSITY**  
**2303 COLLEGE AVENUE**  
**HUNTINGTON, INDIANA 46750**  
**(260) 359-4072 or (260) 359-4092**

\_\_\_\_\_  
Student's Last Name

\_\_\_\_\_  
Student I.D. #



## HEALTH RECORD

### The Information you supply on this health record is kept Confidential

**Note to applicant:** Please complete this form accurately. Your physician will complete the medical examination page at the time of your physical. ALL 3 PAGES OF THIS FORM MUST BE COMPLETED BY ALL FIRST TIME STUDENTS, INCLUDING TRANSFERS, IN ORDER TO ATTEND CLASSES. DEADLINE DATE: August 15 for Fall Semester and January 15 for Spring Semester

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
M.I.

\_\_\_\_\_  
Street

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

( ) \_\_\_\_\_

Phone number

\_\_\_\_\_  
Student SS #

\_\_\_\_\_  
Birth Date

\_\_\_\_ Freshman \_\_\_\_ Sophomore \_\_\_\_ Junior \_\_\_\_ Senior \_\_\_\_ Transfer

\_\_\_\_ residential \_\_\_\_ commuter

**In case of an emergency notify:** \_\_\_\_\_

\_\_\_\_\_  
Name

\_\_\_\_\_  
relationship

\_\_\_\_\_  
Street

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

( ) \_\_\_\_\_

Daytime phone

( ) \_\_\_\_\_

Evening phone

( ) \_\_\_\_\_

Cell phone

\_\_\_\_\_  
Insurance company name

\_\_\_\_\_  
Policy member name

\_\_\_\_\_  
Policy member SS #

\_\_\_\_\_  
Policy member birth date

\_\_\_\_\_  
Group/ID #

( ) \_\_\_\_\_  
Insurance company phone

\_\_\_\_\_  
Insurance company address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Name of Employer

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone



Check the Following that You Have Experienced

- Alcoholism, Allergies, Anemia, Appendicitis, Asthma, Back Injury, Bronchitis-Chronic, Chronic Infection, Colitis-Spastic, Concussion, Congenital Defects, Depression, Diabetes, Dizziness, Eating Disorder, Enlarged Heart, Epilepsy, Eye Problems, Gallbladder Disease, Headaches, Hearing Problem, Heart Disease, Hepatitis, Hiatal Hernia, Hives, Insomnia, Kidney Disease, Mononucleosis, Murmur, Pneumonia, Rheumatic fever, Rheumatoid Arthritis, Suicide Attempt, Thyroid Disease, Tuberculosis, Valve Disease, Other

Family Health:

Father's Health: Good Fair Poor Mother's Health: Good Fair Poor

Number of Brothers and Sisters: Brothers Sisters Their Health: Good Fair Poor

Have you ever been hospitalized? Yes No Explain:

Have you ever had surgery? Yes No Explain:

Indicate which of your close relatives have or have had the following conditions:

- High Blood Pressure, Heart Disease, Mental Illness, Diabetes, Allergies, Alcohol Abuse, Migraine, Tuberculosis, Suicide, Stroke, Epilepsy, Other

Do you take medication for a particular medical condition? (ex.- diabetes, seizures, asthma, depression)

Condition Medication

Is there any apparent reason for restriction of activity? Yes No Explain:

Have you ever been treated for emotional difficulties? Yes No Explain:

Have you ever been treated for an eating disorder? Yes No Explain:

Have you ever been treated for drug abuse? Yes No Explain:

Do you receive allergy shots? Yes No Explain:

Is there any other information the nurse should know? Yes No Explain:

Blank lines for additional information.

NO CLASS PARTICIPATION UNTIL THIS FORM IS COMPLETE!

**PHYSICIAN'S EXAMINATION:**

**Last name** \_\_\_\_\_ **First name** \_\_\_\_\_ **M.I.** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_  
**Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **Pulse** \_\_\_\_\_ **Blood Pressure** \_\_\_\_\_

Region	Pre-entrance		Region	Pre-entrance		Region	Pre-entrance		Allergies: Yes or No Drug: _____ Environment: _____ Other: _____
	Normal	Abnormal		Normal	Abnormal		Normal	Abnormal	
Nose & Throat			Heart			Extremities			
Dental Status			Rhythm			Movement			
Pharynx			Murmurs			Arms			
Other			Abdomen			Legs			
Neck-Thyroid			Tenderness			Hands			
Other			Masses			Feet			
Ears-Hearing			Liver			Orthopedics			
Canals			Spleen			Posture			
Skin Condition			Kidneys			Skeletal Defects			
Nails			Scars			Neurological			
Hair			Genitalia			Tremors			
Chest			Hernia			Speech			
Pulmonary			Pelvic			Vision	<b>R</b>		
Breasts			Scrotum/Testes				<b>L</b>		
Axillary Nodes			Other			Corrected	<b>R</b>		
							<b>L</b>		

**IMMUNIZATIONS RECORD: THIS SECTION MUST BE COMPLETED AT THE TIME OF THE PHYSICAL. ALL STUDENTS, REGARDLESS OF AGE, MUST HAVE DOCUMENTED PROOF OF IMMUNIZATIONS. (LIST DATES).**

DT/DPT \_\_\_\_\_ 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> Booster \_\_\_\_\_ 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup>

OPV/IPV \_\_\_\_\_ 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> Booster \_\_\_\_\_ 1<sup>st</sup>

MMR @ 1 yr.: \_\_\_\_\_ Booster (kindergarten or 6<sup>th</sup> Grade): \_\_\_\_\_

Tetanus Booster (Effective 7-10 years): \_\_\_\_\_

TB Test (Mantoux) (Current this year for 1<sup>st</sup> time students: Date \_\_\_\_\_ Date Read \_\_\_\_\_ Results \_\_\_\_\_)

Meningitis vaccine \_\_\_\_\_ (This vaccine is **required** of all 1<sup>st</sup> year and transfer students).

**\*\*\*\*SUGGESTED VACCINES ONLY - (Not Mandatory)**

Hepatitis B \_\_\_\_\_ 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> Hepatitis A \_\_\_\_\_ 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup>

**ON THE BASIS OF THIS EXAMINATION, I APPROVE THIS STUDENT'S PARTICIPATION IN: (please circle)**

Intercollegiate Sports/Cheerleading with no restrictions:	<b>YES</b>	<b>NO</b>
Physical Education with no restrictions:	<b>YES</b>	<b>NO</b>
Intramurals with no restrictions:	<b>YES</b>	<b>NO</b>

Please note any restrictions or limitations: \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

(As the physician, this student has received the required examination and has received **ALL** necessary immunizations).

**Physician's Signature** \_\_\_\_\_ **Date of Exam** \_\_\_\_\_

**PLEASE RETURN TO: HUNTINGTON UNIVERSITY, STUDENT DEVELOPMENT  
2303 COLLEGE AVENUE, HUNTINGTON, IN 46750  
Questions? Call 260-359-4026**