



The Engle Center for Counseling & Health Services
HEALTH RECORD AND EXAMINATION

PLEASE COMPLETE PRIOR TO PHYSICIAN VISIT

Name (Last, First, MI) _____ D.O.B. _____

- HISTORY
YES NO
1. Have you ever fainted?
During Exercise?
Have you had chest pain during exercise?
2. Family history of sudden death?
Before age 35? Before age 50?
Cause
3. Have you ever had a concussion? How many? number of times you lost consciousness
Dates of concussions
4. Have you ever had heat stroke or heat exhaustion?
5. Do you have a history of asthma?
Do you use inhalers?
6. Do you have any allergies? (medications, bee stings, pollens, foods):
Do you use an EpiPen?
7. Do you take any medications? (including vitamins and nonprescription drugs):
8. Do you have any chronic medical conditions? If yes, explain.
9. Explain any of the following:
Have you ever been hospitalized? If yes, explain.
Have you ever had surgery? If yes, explain.
Have you ever had a serious accident or injury, explain.
10. Have you had a significant joint injury? Specify joint/date
11. Do you have an eating disorder?
12. Circle any of the following you have had:
Abnormal bleeding/bruising Anemia
Broken bones/Stress fracture Diabetes
Dislocation (shoulder, etc.) Hearing impairment
Heart murmur/palpitations/arrhythmias Herpes
Hepatitis/jaundice Other heart anomalies
Loss of eye sight High blood pressure
Scoliosis Rheumatic fever
Sickle-cell disease Seizures
Undescended testicle Single organs (kidney, eye, etc.)
Blood in urine Recurrent skin infections

I do not know of any existing physical conditions or additional health reasons that would preclude my participation in sports. I certify that the answers to the above questions are true and accurate.

Student's Signature _____ Date _____

*If you answered yes, you must have documentation from specialist.



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TO BE COMPLETED BY M.D., D.O., P.A., C.R.N.P.
TO BE COMPLETED BY PROVIDER (within 1 year prior to participation)

PLEASE LIST
DRUG ALLERGIES

Name (Last, First, MI)

Date of Exam Age Date of Birth Sex

HT WT Standing BP Sitting BP Pulse
YES NO Yes No Yes No
Glasses: Vision R L Contact Lenses Anisocoria R L Eye Protection

Table with columns for HEENT, MUSCULOSKELETAL, and other medical categories. Includes checkboxes for Normal (N) or Abnormal (A) and a comments column.

* If answered Abnormal, must have documentation from specialist.

IMMUNIZATION RECORD***PLEASE UPDATE IF NEEDED
Tuberculosis Test (Mantoux only!!) Within 1 year of entering Messiah College.
Date applied Date read Results
If POSITIVE, must have chest xray within 2 years. Date of CXR Results
Tetanus-Diphtheria (booster within the last 10 years) Varicella Vaccine Varicella Disease Date
MMR (Measles, Mumps, Rubella) Dose 1 Dose 2
Measles (Rubeola):Disease Date Mumps Disease Date Rubella Disease Date
Polio: Completed primary series? Yes No Date of last booster
Hepatitis B (opt.) 1. 2. 3.
Hepatitis A (opt.) 1. 2.
Meningococcal Vaccine (Menomune/Menactra), Mandated by PA Legislature 6/28/02
Signed Waiver Date

I have reviewed the medical history and herewith certify that the above student has been evaluated in the following areas as indicated below to be physically fit to participate in collegiate, club sport, and recreational sport activities.

Table with columns: Medical History, Medical Exam, Musculoskeletal, Y/N, Normal/Abnormal, Collegiate Sports, Contact Sports, Noncontact Sports, Cleared for, Not Cleared for.

Due to (if not cleared)

Modifications or exceptions:

How long have you been patient's physician?

Signature of Provider: Print Name:

Address:

Phone Number: Fax Number: