TO THE PARENTS OF ST. ANDREWS PRESBYTERIAN COLLEGE STUDENT-ATHLETES

We are extremely pleased to have your son/daughter as a student-athlete at St. Andrews and hope that he/she will achieve academic, social, and athletic success!

Enclosed are several forms for your completion. Please make sure all questions are answered. Also, please sign in the appropriate space provided. A copy of your current insurance card (front and back) must be provided to both student health and athletics.

THE STUDENT/ATHLETE WILL NOT BE ALLOWED TO PARTICIPATE UNTIL ALL FORMS WITH SIGNATURES ARE RETURNED.

Each student/athlete is required to have a physical examination prior to any participation in any intercollegiate sport. In the information you will find the student health form required for new and transfer students coming into St. Andrews at the end of the document. This entire document (Student Health and Wellness form) must be completed and returned to student health. For athletics, you will need to copy the fourth page - **Report of Health Evaluation - Physician's Form** and return with all the other documents preceding the Student Health and Wellness form.

So there is no confusion, the following should be returned to the department of athletics:

Medical History Form (4 pages)
Emergency Consent and Health Information Form
Nutritional Supplement and Review Disclosure (must be signed even if you are not taking supplements)
Urinalysis Authorization and Release Consent
Report of Health Evaluation – Physician's Form (4th page of Student Health and Wellness Form)
Copy of front and back of your insurance card

The 6 page Student Health and Wellness Form should be returned to student health.

If there is no physical or paperwork on file prior to the first practice, the athlete will be required to complete all paperwork, provide a copy of their insurance card and have a physical prior to participation. To avoid any delays, please schedule with your family physician back home in plenty of time to get the required physical completed prior to your arrival on campus.

The final decision on physical qualifications or reason for rejection is the responsibility of the team physician, athletic trainer, or athletic director. The team physician or athletic trainer also will make the decision on when an athlete may return to competition after an injury.

We want to thank you for your cooperation in this matter. We know it is time consuming to fill out the forms but it really make our job much easier. If you have any questions, please contact either the athletic trainers or athletic director.

Thank you,

St. Andrews Athletic Training
St. Andrews Athletic Department

ST ANDREWS PRESBYTERIAN COLLEGE ATHLETIC DEPARTMENT
MEDICAL HISTORY FORM (New and Transfer Students Only)

Name of Athlete: ______________________________ Date: ______________

Date of Birth: / / Age: _____ Sex: M F Social Security #: ______________

MEDICAL HISTORY: Please answer each of the following questions by circling YES or NO. Answer all questions fully and provide explanation for each "YES" in the space provided. Failure to disclose any medical information may invalidate insurance coverage. The information provided is strictly confidential and used for health care purposes only.

Family History:

Has any parent, grandparent, or sibling had:

Cancer	YES	NO	________
Leukemia	YES	NO	________
Tuberculosis	YES	NO	________
Diabetes	YES	NO	________
Heart disease	YES	NO	________
High blood pressure	YES	NO	________
Asthma	YES	NO	________
Liver disease	YES	NO	________
Migraine headaches	YES	NO	________
Emphysema	YES	NO	________
Stroke	YES	NO	________
Epilepsy/Seizures	YES	NO	________
Bleeding disorder	YES	NO	________
Kidney disease	YES	NO	________
Glaucoma	YES	NO	________
Sickle cell anemia	YES	NO	________
Arthritis	YES	NO	________
Alcohol or drug abuse	YES	NO	________
Nervous or mental disease	YES	NO	________
Sudden death before age 50	YES	NO	________
Any other serious disease	YES	NO	________

Medications:

Are you currently taking any medications?
(Birth control, ADHD, insulin, thyroid, etc)
Yes No
If so, list medications taken on regular basis

____
____
____
____
____

Allergies:

Do you have an allergies to:

Penicillin	YES	NO	________
Sulfa	YES	NO	________
Aspirin	YES	NO	________
Codeine	YES	NO	________
Other drugs/medicine	YES	NO	________
Foods	YES	NO	________
Insect bites	YES	NO	________
Hay fever	YES	NO	________
Seasonal allergies	YES	NO	________
Latex	YES	NO	________
Iodine or Betadine	YES	NO	________
Other:	YES	NO	________

Personal History:

Do you smoke?	YES	NO	________
Do you use any other forms of tobacco?	YES	NO	________
Do you drink?	YES	NO	________
If yes, how much?			
Do you use drugs?	YES	NO	________
Are you on a special diet?	YES	NO	________
Have you lost weight in the past year?	YES	NO	________
Are you satisfied with your weight?	YES	NO	________
Do you think you have an eating disorder?	YES	NO	________

Women Only

Mentrual Difficulty	YES	NO	________
Ovarian Cyst	YES	NO	________
Regular Periods	YES	NO	________
Breast Lump	YES	NO	________
Other GYN problems	YES	NO	________

Men Only

Loss of testicle	YES	NO	________
Other	YES	NO	________

ST ANDREWS PRESBYTERIAN COLLEGE ATHLETIC DEPARTMENT
MEDICAL HISTORY FORM (New and Transfer Students Only)

Health History:

Do you have now or have you had in the past, any of the following:

Condition			
Concussion	YES	NO	______
Loss of consciousness	YES	NO	______
Memory loss	YES	NO	______
Numbness/weakness in an arm or leg	YES	NO	______
Migraine headaches	YES	NO	______
Mouth/tooth/tongue problem	YES	NO	______
Recurrent nosebleeds	YES	NO	______
Broken nose	YES	NO	______
Epilepsy/seizures	YES	NO	______
Heat related illness	YES	NO	______
Glaucoma	YES	NO	______
Cataracts	YES	NO	______
Blindness (either eye)	YES	NO	______
Blurred vision (not corrected by glasses)	YES	NO	______
Ear infections	YES	NO	______
Deafness/Hearing Deficinecy	YES	NO	______
Difficulty sleeping	YES	NO	______
Sleep apnea	YES	NO	______
Asthma	YES	NO	______
Currently taking medication for this?	YES	NO	______
Name of medication			______
Shortness of breath/wheezing	YES	NO	______
Coughing up blood			______
Hay Fever			______
Chronic bronchitis	YES	NO	______
Tuberculosis	YES	NO	______
Heart murmur	YES	NO	______
Pain/pressure in chest	YES	NO	______
Depression/Anxiety	YES	NO	______
Serious emotional illness	YES	NO	______
Marfan's Syndrome	YES	NO	______
Rheumatic fever	YES	NO	______
High blood pressure	YES	NO	______
Mononucleosis	YES	NO	______
Hepatitis or Jaundice	YES	NO	______
Acid Reflux disease	YES	NO	______
Crohn's Disease	YES	NO	______
Digestive disorder	YES	NO	______
Colon trouble	YES	NO	______
Rectal trouble	YES	NO	______
Bladder infection	YES	NO	______
Urinary track infection	YES	NO	______
Appendicitis	YES	NO	______
Surgery required?	YES	NO	______
Kidney infection	YES	NO	______
Kidney stones	YES	NO	______
Anemia	YES	NO	______
Bleeding disorder	YES	NO	______
Hernia	YES	NO	______
Absence of paired organ	YES	NO	______
Diabetes	YES	NO	______
Currently taking medication for this?	YES	NO	______
Name of medication?			______
Thyroid problems	YES	NO	______
Arthritis	YES	NO	______
Phlebitis	YES	NO	______
Recurrent boils	YES	NO	______
Changing moles	YES	NO	______
Other skin disease	YES	NO	______

Other problems not mentioned:

____

Musculoskeletal History:

Shin, Ankle & Foot:

Question			
Have you ever had a serious ankle, foot or shin injury which required a doctor's visit?	YES	NO	______
Was surgery performed?	YES	NO	______
Have you ever sustained severe shin splints or a stress fracture to your shin?	YES	NO	______
Do you have any chronic pain, swelling, burning, numbness or tingling in your shin, ankle or foot?	YES	NO	______
Does your ankle feel "unstable" or as though it wants to "buckle" or "give way"?	YES	NO	______
Does your ankle require taping or other support on a regular basis?	YES	NO	
Have you had any severe heel, arch, foot or toe injuries?	YES	NO	______
Do you wear orthotics?	YES	NO	______

ST ANDREWS PRESBYTERIAN COLLEGE ATHLETIC DEPARTMENT
MEDICAL HISTORY FORM (New and Transfer Students Only)

Knee:

Have you ever had a serious knee injury which required a doctor's visit? YES NO ____________
Was surgery performed? YES NO ____________
Do you wear a knee brace? YES NO ____________
Did you have ligament damage? YES NO ____________
Did you have cartilage or meniscus damage? YES NO ____________
Have you sustained a severe case of patellar tendinitis or "jumper's knee"? YES NO ____________
Have you sustained a severe kneecap (patella) dislocation or "slippage"? YES NO ____________
Do you have chronic knee pain, "popping", "clicking", snapping or swelling? YES NO ____________
Does your knee feel "unstable" or as though it wants to "buckle" or "give way"? YES NO ____________

Hip & Thigh:

Have you ever had a serious hip or thigh injury which required a doctor's visit? YES NO ____________
Have you ever sustained a severe sprain, contusion or dislocation to your hip or thigh? YES NO ____________
Have you ever sustained a severe muscle strain or bruise to either the hamstrings, quadriceps or groin ? YES NO ____________
Does your hip or thigh have constant pain, "pop", "snap", or "click" with athletic activity or running? YES NO ____________

Back:

Have you ever had a serious back injury which required a doctor's visit? YES NO ____________
Have you ever sustained a disk rupture or a "slipped" disk to your back? YES NO ____________
Do you have any pain, burning, numbness or tingling in your back or going down into the back of your leg? YES NO ____________
Have you ever been told your back is "out of line"? YES NO ____________
Do you suffer from chronic back pain, soreness or stiffness? YES NO ____________

Shoulder:

Have you ever had a serious shoulder injury which required a doctor's visit? YES NO ____________
Was surgery performed? YES NO ____________
Have you ever dislocated or separated your shoulder? YES NO ____________
Have you ever sustained a severe strain or tear to your rotator cuff? YES NO ____________
Does your shoulder feel unstable, slips out or wants to come out? YES NO ____________
Do you have problems with throwing or overhead shoulder activities? YES NO ____________
Have you ever been told that you have a cartilage, labrum or a SLAP lesion? YES NO ____________
Have you ever been advised to have surgery to correct a shoulder problem? YES NO ____________

Elbow, Wrist, Hand & Fingers:

Have you ever had a serious elbow, wrist, hand or finger injury which required a doctor's visit? YES NO ____________
Was surgery performed? YES NO ____________
Do you get elbow pain with throwing or any burning, numbness or tingling with throwing? YES NO ____________
Do you have any chronic pain or burning, numbness or tingling to your wrist, hand, thumb or fingers? YES NO ____________

ST ANDREWS PRESBYTERIAN COLLEGE ATHLETIC DEPARTMENT
MEDICAL HISTORY FORM (New and Transfer Students Only)

Head, Neck, Chest and General Injury Assessment:

Have you ever been "knocked out" or lost consciousness for any reason? YES NO ______

Have you ever sustained a concussion or head injury? YES NO ______

If yes, how many times has this occurred and what are the dates of injury? YES NO ______

Have you ever had a "burner", "stinger" or "pinched nerve" in your neck? YES NO ______

Have you ever sustained an abdominal, chest or rib injury? YES NO ______

Have you ever had a fracture or sustained a broken bone? YES NO ______

Do you have any pins, screws, metal plates or bone graft in your body as a result of a surgery? YES NO ______

Authorization and Consent:

This authorization is required to comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA was created to protect the privacy of personal health information (PHI). HIPAA regulations prohibit disclosure of PHI unless written authorization is given. Therefore, in order to communicate with yoiur coaches, parents/guardian, or other health care providers about your injury and/or condition, the athletic training staff must obtain your permission.

A. I have personally reviewed the information provided in this Medical History Summary and attest that it is true and complete to the best of my knowledge.
B. I understand that participation in sports require an acceptance of risk for injury.
C. I authorize any medical treatment for my myself (son/daughter) that may be advised or recommended by the athletic training staff, including physician referral. I understand that I am responsible for all medical costs incurred by physician referral is necessary.
D. I understand that I (my son/daughter) must refrain from practice or play while injured or ill until I (he/she) am/is discharged from treatment or given permission by the athletic training staff to restart participation despite continuing medical treatment
E. I understand having passed the sports physical examimation does not necessarily mean that I (my son/daughter) am/is physically qualified to engage in intercollegiate athletics, but only that the examiner did not find a medical reason to disqualify at the time of said examination.
F. I hereby give permission to the athletic training staff to disclose my (my son/daughter) personal health information when it pertains to my (his/her) athletic injury/illness, treatment, and/or ability to participate in collegiate athletics to my (his/her) coaches, parents/guardian, and/or other health care providers involved in my (his/her) medical care (i.e. SAPC Health and Wellness, referring physicians, etc.).
G. I understand that if I feel my privacy has been violated without my consent, I may file a complaint to the U.S. Health and Human Resources Department.

Injury and Concussion Acknowledgement:

I acknowledge that I have to be an active participant in my own healthcare. As such, I have the direct responsibility for reporting all of my injuries and illnesses to the sports medicine staff of my institution (i.e. team physician, athletic trainer, etc). I recognize that my true physical condition is dependent upon an accurate medical history and full disclosure of any symptoms, omplaints, prior injuries and/or disabilities experienced. I hereby affirm that I am fully disclosinig in writing any prior medical conditions and will also disclose any future conditions to the sports medicine staff at my institution.

I further understand that there is a possibility that participation in my sport may result in a head injury and/or concussion. I have been provided witheducation on head injuries and understand the importance of immediately reporting symptoms of a head injury/concussion to my sports medicine staff.

By signing below, I acknowledge that my institution has/will provided me with specific educational materials on what a concussion

We/I the undersigned below have read and fully understood the preceding policy and statements under "Authorization and Consent" and Injury and Concussion Acknowledgement. We/I hereby release St. Andrews Presbyterian College, its agents and employees, particularily the athletic training staff, from any liability caused by, or arsing out of my athletic participation in the St. Andrews Presbyterian College Athletic Program.

Student Athlete Signature: ______________________ Date: __________

Signature of Parent/Guardian: ______________________ Date: __________

ST ANDREWS PRESBYTERIAN COLLEGE ATHLETIC DEPARTMENT
EMERGENCY CONSENT and HEALTH INFORMATION FORM

Name of Athlete: ______________________ Date: __________

Sport MSOC WSOC VB CC MBK WBK BB SB GOLF MLAX WLAX WR

Date of Birth: ___/___/_____ Age: _____ Sex: M F Social Security #: __________

College/Local Address:	Home/Permanent Address:
Street	Street
City State Zip	City State Zip
( ) **Athlete Cell Phone #**	( ) Home Phone

FATHER's Information:	MOTHER's Information:
Full Name:	Full Name:
DOB:	DOB:
Social Security #:	Social Security #:
Employed By:	Employed By:
Work Phone:	Work Phone:
Medical Insurance Plan:	Medical Insurance Plan:
Insurance Plan Address	Insurance Plan Address
Policy Number	Policy Number
Group Number	Group Number
Is son/daughter covered under this policy? ◻ YES ◻ NO	Is son/daughter covered under this policy? ◻ YES ◻ NO
Is this plan an HMO or PPO? ◻ YES ◻ NO	Is this plan an HMO or PPO? ◻ YES ◻ NO
Is pre-authorization required for treatment? ◻ YES ◻ NO	Is pre-authorization required for treatment? ◻ YES ◻ NO
Is a second opinion required for surgery? ◻ YES ◻ NO	Is a second opinion required for surgery? ◻ YES ◻ NO

Primary Care Physician ______________________ Phone ______________

Previous Injuries/Surgeries: ______________________

Allergies: ______________________

Medications Used Regularly: (Include inhalers, birth control, etc) ______________________

Person to notify in case of emergency (other than parent):

Name: ______________________ Relationship to athlete: ______________

Phone: ______________________ Alternate Phone: ______________

Emergency Statement:

I grant permission for transportation and treatment necessary for a condition arising during participation in sports, including medical or surgical treatment recommended by a medical doctor. I understand every effort will be made to contact my nearest relative prior to treatment.

Insurance Statement

I hereby authorize St. Andrews College, First Agency Insurance Company and its representatives to secure copies of case history records, laboratory reports, diagnosis, x-rays and any other data covering this and/or disabilities. A photostatic copy of this authorization shall be deemed effective and valid as the original.

Parent's Signature: ______________________ Date: __________

Student's Signature: ______________________ Date: __________

INSURANCE CARDS

ALL ATHLETES MUST
MAKE A COPY OF YOUR
CURRENT INSURANCE
CARD (FRONT AND BACK)
AND RETURN WITH ALL
THE PAPERWORK.

THANK YOU!

St. Andrews Presbyterian College Athletic Department
Student-Athlete Nutritional Supplement Disclosure and Review Form

I, the undersigned, am taking or intend to take the following nutritional supplements. I acknowledge the risk of losing my eligibility to participate in intercollegiate athletics if I test positive for an NCAA banned substance that may be found in any substance that I may take, regardless of the reason or purpose for taking such supplements. I acknowledge the possible health risks that may be associated with taking an over-the-counter nutritional supplement.

I acknowledge and understand that the labeling on these products can be misleading and inaccurate because they are not regulated by the Food and Drug Administration (FDA) and that sales personnel are paid to sell these products and cannot accurately certify that these products contain no substances banned by the NCAA. Terms such as "healthy" or "naturally occurring" do not necessarily mean safe to take or safe to use, or that the NCAA endorses a product or approves its usage. In other words, what's in the bottle is not always on the label. If I do not know what I'm taking, I'm risking both my health and my eligibility.

The NCAA does not accept ignorance as an excuse following a positive drug test for a banned substance. Before taking or using any supplement, I am responsible for taking appropriate steps to ensure that it does not contain any substance banned by the NCAA. By making this disclosure, I am requesting that these products and their ingredients be reviewed by my institution's head athletic trainer for the purposes of determining whether they are medically safe to use and do not contain substances banned by the NCAA. I understand that I should not take or use these products until their usage has been approved by my institution's head athletic trainer.

Brand Name	Listed Ingredients
1.______________________	______________________
	______________________
	______________________
2.______________________	______________________
	______________________
	______________________
3.______________________	______________________
	______________________
	______________________

Printed Name ______________________________ Sport ______________

Athlete Signature ______________________________ Date ____/____/____

Do Not Write In This Box
Reviewed by Staff Athletic Trainer: ______________________________ Date ____/____/____

Substance Listed are: Banned _____ Acceptable _____ Do Not Take _____

St. Andrews Presbyterian College Athletic Department
Urinalysis Authorization and Release Consent

I, the undersigned, have had an opportunity to review the St. Andrews Presbyterian College Drug Testing Program and agree as a participant in the collegiate athletics program to be a part of this testing. I will also have the opportunity to ask questions and fully understand the provisions of the program. I consent to the taking of such samples if required, and understand that the testing will be done by a laboratory employee of the College.

I understand that the results will be treated confidentially, but I consent to the release of the results to the Athletic Director, Athletic Trainer and to my parents and/or guardian. If the Athletic Director feels it necessary, the team coach will be notified. I also consent to the release of these results to any other party deemed necessary by the Athletic Director for the purpose of special counseling or medical treatment.

I understand that I am free to withdraw this consent for urinalysis testing. However, I also understand that should I do so or refuse to submit to testing at the time requested, I will not be permitted to participate in any intercollegiate sporting program, and may lose my athletic financial aid.

I hereby release St. Andrews Presbyterian College, its Trustees, Officers, Employees, Agents, and Representatives from legal responsibility or liability for the release of such information and records as authorized by this form. ***By signing this consent, you agree that it will remain a valid consent form from the date signed until the day after you are not enrolled at St. Andrews.***

______________________________	______________________________
PRINTED NAME OF STUDENT ATHLETE	SPORT(S)
______________________________	______________________________
SIGNATURE OF STUDENT ATHLETE	DATE

****

______________________________	______________________________
SIGNATURE OF PARENT OR LEGAL GUARDIAN (If student is under 18 years of age)	DATE

St. Andrews Presbyterian College Student Health & Wellness Center
Health Information Summary

Students and Parents

- Students may not move on campus or register for classes until cleared by Health Services.
- Please type or print with ink.
- Please mail the completed form directly to:
  Health and Wellness Services
  St. Andrews Presbyterian College
  1700 Dogwood Mile
  Laurinburg, NC 28352
- *Questions?* **Phone (910) 277-5040.**

***Notice:** Do Not Mail Until Form is Complete.*
Must Be Returned by Aug. 1

Student's Full Name ______________________ (Last) ______________________ (First) ______________________ (Middle) Phone (C)______________

Home Address ______________________ (Street) ______________________ (City/State) ______________________ (Zip Code) Phone (H)______________

Date of Birth_____/_____/_____ Marital Status_______ Sex _______ Age _____ Social Security No.______________________

Date entering SAPC______________________ Undergraduate: ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior

Name of Next of Kin ______________________ Relationship______________________ Phone (H) ______________

Address of Next of Kin ______________________ (Street) ______________________ (City/State) ______________________ (Zip Code)

Business Address of Next of Kin ______________________ (Street) ______________________ (City/State) ______________________ (Zip Code) Phone (O) ______________
Phone (C) ______________

Name of Other Emergency Contact ______________________ Relationship ______________ Phone (H) ______________

Emergency Contact Address______________________ (Street) ______________________ (City/State) ______________________ (Zip Code) Phone (O) ______________
Phone (C) ______________

USA Citizen? ☐ Yes ☐ No If no, what is your nationality?______________________

Authorization and Consent

(A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless by Court Order. However, if I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission for the Student Health Service to release information from my (son's/daughter's) medical record to a physician, hospital, or other medical agency involved in providing me (him/her) with emergency treatment and/or medical care.

(B) I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the physicians of the Student Health Services. I understand that I am responsible for all medical costs incurred.

Signature of Student ______________________________ Date ______________

Signature of Parent/Guardian
(if student is under age 18) ______________________________ Date______________

Health Insurance Information Required. Please Submit Both Sides of Insurance ID Card.

Name of Insurance Company______________________ Subscriber ID# ______________ Group # ______________

Address of Insurance Company______________________ Subscriber's Name ______________________

Is **PREADMISSION CERTIFICATION** required by your insurance carrier? ☐ Yes ☐ No If yes, provide Phone #______________

Student's Full Name ____
Last First Middle Nickname

Medical History

Please complete this section before going to your physician for examination. You have been accepted. The information supplied will not affect your admission status; it will be utilized for health care purposes only.

Family History - Please Answer All Questions

Family History	Age	State of Health	Occupation	Age of Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Have any of your relatives ever had any of the following?	Yes	No	Relationship
Alcohol or Drug Abuse			
Arthritis			
Asthma			
Blood or clotting disorder			
Cancer			
Depression/Anxiety			
Diabetes			
Epilepsy or seizures			
Heart disease			
High blood pressure			
Kidney disease			
Migraine headaches			
Nervous or mental disease			
Suicide attempt			
Tuberculosis			
Ulcer or intestinal disease			

Remarks or Additional Information:

____

____

____

____

____

____

____

____

____

____

Personal History: Please Answer All Questions

Comment on all positive answers under remarks

Have you ever had any of the following?	Yes	No	Year
Scarlet Fever			
Measles			
German Measles			
Mumps			
Chicken Pox			
Malaria			
Infectious Mono.			
Gum or tooth trouble			
Sinusitis			
Eye trouble			
Ear, nose, throat trouble			
Surgery			
Appendectomy			
Tonsillectomy			
Hernia repair			
Other (specific)			
Alcohol or substance abuse problem			

Have you ever had any of the following?	Yes	No	Year
Pain/pressure in chest			
Bronchitis			
Palpitations (heart)			
High or low blood pressure (circle)			
Rheumatic Fever			
Heart Murmur			
Arthritis			
Injury to joints			
"Trick" knee, shoulder			
Back problems			
Tumor, Cancer			
Jaundice - Hepatitis			
Stomach/Intestinal trouble			
Insomnia			
Anemia			

Have you ever had any of the following?	Yes	No	Year
Frequent anxiety			
Frequent depression			
Worry or nervousness			
Recurrent headaches			
Recurrent colds			
Head injury with unconsciousness			
Hay Fever			
Asthma			
Tuberculosis			
Shortness of breath			

Have you ever had any of the following?	Yes	No	Year
Gallbladder disease			
Diabetes			
Recurrent diarrhea			
Rupture, hernia			
Kidney/bladder disease or infection			
Dizziness, fainting			
Weakness/paralysis			
Albumin (sugar in urine)			
Convulsions/seizures			
Eating disorders			
FEMALES ONLY			
Irregular periods			
Severe cramps			
Excessive flow			
Average days/period:			

Statement By Student

I have personally supplied all of the above information and attest that it is true and complete to the best of my knowledge.

____

Signature of Student

____

Date

Medical History Continued

Check each item **Yes** or **No**. Every item checked Yes must be fully explained in the space on the right (or on an additional sheet of paper).
Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If **Yes**, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

Have you ever had adverse reactions to any of the following:	Yes	No	Explanation/Year?
Penicillin			
Sulfa			
Other antibiotics (please specify)			
Aspirin			
Codeine or other pain relievers			
Other drugs, medicines, chemicals (please specify)			
Insect bites/stings			
Food allergies (please specify)			

	Yes	No	Explanation/Year?
Do you have any conditions or disabilities that limit your physical activities? If Yes, please describe.			
Have you ever been a patient in any type of hospital? If Yes, please specify when, where and why.			
Has your academic career been interrupted due to physical or emotional problems? If Yes, please explain.			
Is there loss or seriously impaired function of any paired organs? If Yes, please explain.			
Other than a routine check-up, have you seen a physician or health care professional in the past six months? If Yes, please explain.			
Have you ever had any serious illness or injuries other than those already noted? If Yes, give details, specifying when and where.			

Student's Full Name ____
Last First Middle Nickname

Social Security Number____________________ Date of Birth:________________

Report of Health Evaluation - Physician's Form

To the Examining Physician: Please review the student's history and complete the physician's form. Please comment on all positive answers. **This student has been accepted.** The information supplied will not affect his/her status; it will be used only as a background for providing health care. This information is strictly for the use of Student Health Services and will not be released without student consent.

Thank you for your cooperation in completing this form.

Uncorrected Vision: Right 20/_____ Left 20/_____
Corrected Vision: Right 20/_____ Left 20/_____
Height: _______ inches
Weight: _______ pounds
Blood pressure: _______/______
Pulse: _____________

Are there any abnormalities of the following systems? Please attach a full description.

Systems	Yes	No
Head, Ears, Nose or Throat		
Respiratory		
Cardiovascular		
Gastrointestinal		
Hernia		
Eyes		
Genitourinary		
Musculoskeletal		
Metabolic/Endocrine		
Neuropsychiatric		
Skin		
Is there loss or seriously impaired function of any organ?		

List any drugs, medicines, birth control pills and vitamins (prescription and non-prescription) used, frequency of use and dosage.

Name of drug/vitamin	Frequency of Use	Dosage

Required Procedures

Urinalysis:
Date ________________
Sugar________________
Albumin______________
Micro.______________

Hemoglobin or Hematocrit:
____

Recommendations for physical activity (PE, Intramurals, etc.):
❑ Limited ❑ Unlimited Explain below:

____
____
____
____
____

Do you have any recommendations regarding the care of this student?
❑ Yes ❑ No Please attach supporting documentation.

Is this student now under treatment for any medical or emotional condition?
❑ Yes ❑ No Please attach supporting documentation.

Does Student Health Services need to participate in treatment of any kind?
❑ Yes ❑ No Please attach supporting documentation.

Have you any general comments? ❑ Yes ❑ No

____
____

Does this student have a condition requiring special housing considerations?
❑ Yes ❑ No Please attach supporting documentation.

Is this student physically cleared to participate in NCAA athletics?
❑ Yes ❑ No ❑ N/A

Is this student physically cleared for participation in the equestrian program?
❑ Yes ❑ No ❑ N/A

Signature of Physician______________________________
Print Name Here______________________________
Address______________________________
Business Phone ____________________ Date ______________

Please Notify St. Andrews Presbyterian College Student Health Services of ANY Medical Problems Which Develop After This Examination.

St. Andrews Presbyterian College Student Health & Wellness Center
Student Health Services Immunization Record

To be completed by Physician.

Student's Full Name ____
Last First Middle Nickname

Home Address ____ Phone (H)____________
Street City/State Zip Code

North Carolina State Law required vaccinations are as follows: MMR, Tetanus-Diphtheria, and Tuberculosis. These vaccinations must be completed prior to arriving on campus. If a student does not receive required immunizations prior to campus registration, additional charges may occur.

To Be Completed and Signed by Your Healthcare Provider. All information must be in English.

1. M.M.R. (Measles, Mumps, Rubella) (two doses required.)

A. Dose 1 given at age 12-15 months or later ....#1_______/_______
M Y

B. Dose 2 given at age 4-6 years or later, and at least one month after first dose ....#2_______/_______
M Y

2. Tetanus-Diphtheria (Primary series with DtaP or DTP and booster.)

A. Primary series with four doses with DtaP or DTP: If your last DtaP or DTP was over 10 years ago you must have a Td booster.
#1____/____ #2____/____ #3____/____ #4____/____
M Y M Y M Y M Y

B Tetanus-Diphtheria (Td) _____/_____ **Must be within the last 10 years.**
M Y

3. Tuberculosis Screening

A. Tuberculin Skin Test: **Must be within the last year.**

Date given: _____/_____/_____ Date read: _____/_____/_____
M D Y M D Y

Result: ____________ (Record actual mm of induration, transverse diameter; if no induration, write "0")

Interpretation (based on mm of induration as well as risk factors): positive _____ negative _____

B. Chest x-ray (required if tuberculin skin test is positive) result: positive _____ abnormal _____

Date of the chest x-ray:_____/_____/_____
M D Y

Health Care Provider

Printed Name ______________________________ Address______________________________

Signature ______________________________ Phone ( ) ______________________________

This form is for additional immunization(s) the student may have received. They are not required for college entry per North Carolina state law. Health and Wellness does not provide hepatitis B or meningococcal vaccinations. We strongly recommend students receive them. These must be given by your health care provider.

1. Hepatitis B (three doses of vaccine or positive Hepatitis surface antibody meets the requirement)

A. Immunization

Dose #1 ____/____ (M Y) Dose #2 ____/____ (M Y) Dose #3 ____/____ (M Y)

B. Hepatitis B surface antibody Date ____/____ (M Y) Result: Reactive ______ Non-reactive ______

2. Meningococcal (One dose – preferably at entry into college for freshmen living in residence halls who wish to reduce their risk of meningococcal disease. Undergraduates less than 25 years old who wish to reduce their risk of disease can consider the vaccine. Students with immunodeficiency such as complement deficiency or asplenia should receive vaccine every 3-5 years.

Quadrivalent polysaccharide vaccine .... Date ____/____ (M Y)

3. Polio (Primary series in childhood meets requirements; three primary series schedules are acceptable.)

A. OPV alone (Oral Sabin three doses): #1 ____/____ (M Y) #2 ____/____ (M Y) #3 ____/____ (M Y)

B. IVP alone (injected Salk four doses): #1 ____/____ (M Y) #2 ____/____ (M Y) #3 ____/____ (M Y) #4 ____/____ (M Y)

C. IPV/OPV sequential: IPV #1 ____/____ (M Y) IPV #2 ____/____ (M Y) OPV #3 ____/____ (M Y) OPV #4 ____/____ (M Y)

4. Varicella (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized after age 13 years meets the requirement.)

A. History of disease Yes _____ No _____

B Varicella antibody ____/____ (M Y) Reactive _____ Non-reactive _____

C. Immunization

1. Dose #1 #1 ____/____ (M Y)

2. Dose #2, given at least one month after first dose, if age 13 years or older #2 ____/____ (M Y)

Health Care Provider

Printed Name ______________________________ Address ______________________________

Signature ______________________________ Phone (   ) ______________________________