

MEDICAL HISTORY QUESTIONNAIRE

Last Name	First Name	Middle Name
Sport(s) if applicable	Class	Age
	Date of Birth	Student's Cell Phone #
Parent/Guardian's Name	Home Address	City/State/Zip
		Home Phone

The following information is vitally important for screening newly admitted students as well as returning athletes. Please answer ALL questions honestly. The medical information that you share is kept confidential and will only be shared with authorized medical providers and athletic training staff when necessary. This medical history MUST be completed prior to entrance to Bridgewater College and athletic participation.

Check all that apply to your current or past medical history:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Absent organ | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Physical handicap |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Bone/joint injury |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Latex sensitivity | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Gastric reflux | <input type="checkbox"/> Malaria | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Migraines | <input type="checkbox"/> Marfan's Syndrome |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Spinal Stenosis |

Please check "yes" or "no" for the following questions. If answering "yes" please explain in the provided space found on the back of this sheet.

YES NO

- YES NO 1. Have you had a medical illness in the past 12 months?
- YES NO 2. Have you been hospitalized overnight?
- YES NO 3. Have you undergone surgery for a medical condition or injury?
- YES NO 4. Do you experience frequent headaches?
- YES NO 5. Do you have missing organs?
- YES NO 6. Has any of your family members died of heart problems or sudden death before age 50?
- YES NO 7. Do you ever experience shortness of breath during or after exercise?
- YES NO 8. Do you experience wheezing during or after exercise?
- YES NO 9. Do you use an inhaler?
- YES NO 10. Do you have a skin condition?
- YES NO 11. Do you have hearing problems?
- YES NO 12. Do you have problems with your vision?
- YES NO 13. Do you wear glasses or contacts while participating in athletics?
- YES NO 14. Are you currently taking over-the-counter medications?
- YES NO 15. Are you currently taking prescription medications?
- YES NO 16. Are you currently taking herbal or nutritional supplements?
- YES NO 17. Are you allergic to any medications?
- YES NO 18. Are you allergic to any foods?
- YES NO 19. Are you allergic to latex products?
- YES NO 20. Do you have any other allergies not described above?

Please check "yes" or "no" for the following questions. If answering "yes" please explain in the provided space at the end of the page.

YES NO

- 21. Has your weight changed within the last 12 months?
- 22. Do you feel that you need to gain or lose weight?
- 23. Have you ever tried to use diet pills, diuretics, laxatives, vomiting or a similar technique to lose weight?
- 24. Do you experience irregular menstrual periods?
- 25. Do you use tobacco products?
- 26. Within the last year, have you been seriously injured while participating in athletics?
- 27. Have you suffered any abdominal or chest injuries?
- 28. Have you suffered internal injuries?
- 29. Have you suffered ear, nose or throat injuries?
- 30. Have you suffered any bone, joint or muscle injuries?
- 31. Have you suffered a head injury or concussion? How many? When?
- 32. Have you lost consciousness due to a head injury or concussion? How long?
- 33. Have you experienced memory or concentration problems due to a head injury or concussion?
- 34. Have you missed a practice or competition due to a head injury or concussion?
- 35. Do you currently experience problems due to a past head injury or concussion?
- 36. Have you become ill from exercising in the heat?
- 37. Have you received an X-ray, MRI or bone scan within the last 12 months?
- 38. Has a medical professional recommended the use of tape or other protective bracing while participating in athletics?
- 39. Has a medical professional recommended orthotic devices or arch supports for participation in athletics?
- 40. Have you been advised by a medical professional NOT to participate in athletics?
- 41. Have you NOT been allowed to participate in an athletic event because of an injury or medical condition?
- 42. Do you know of any health reason why you should NOT participate in Bridgewater College athletics?

Explain all "yes" answers or provide other pertinent medical information in the following space:

I hereby state to the best of my knowledge the answers provided are correct. I have not withheld any health information important to my safety.

Signature of Student/Athlete

Date

**Signature of Parent/Guardian

Date

**Needed if student/athlete is under 18 years of age

ENTRANCE PHYSICAL AND ATHLETIC PARTICIPATION EXAMINATION FORM

To be completed by medical professional.

Name: _____ Age: _____ Date of Birth: _____ Date of Examination: _____

General Information

 Height: _____ Weight: _____ BP: _____ U/A: _____ Pulse: _____ Sex: M F

 Vision: R 20/ _____ L 20/ _____ Corrected: YES NO Any missing or nonfunctioning organs? YES NO

Hgb _____ gm/100ml Hct _____ %

Information Requiring Medical Clearance

Examined Area	Normal	Abnormal Findings (explanation)
Lungs/Chest		
Heart		
Pulses		
Skin		
Eyes/Ears/Nose/Mouth		
Abdominal		
Genitalia		
Musculoskeletal		
Neck		
Shoulder		
Elbow		
Wrist/Hands		
Back		
Knees		
Ankles/Feet		
Reflexes		
Other		

Patient Education

Item Reviewed	Yes	No	N/A
Medical History Questionnaire			
Sexual Health Education			
Nutritional and dietary supplements			

Participation Status

- Cleared for ALL athletic and academic pursuits
 Cleared after completing evaluation and/or treatment for: _____
 Not cleared for:
 { } Academic Pursuits { } Collision sports (e.g. football)
 { } Contact sports (e.g. basketball)
 _____ Strenuous _____ Moderately strenuous _____ Non-strenuous

Due to: _____ Recommendations: _____

Medical Professional Information

Examiner Name (Printed): _____ Signature (MD, NP, PA, DO): _____

Address of Medical Facility: _____ Phone: _____ Date of Examination: _____

BRIDGEWATER COLLEGE

DEEMED CONSENT FORM

Notice of Deemed Consent to HIV & Hepatitis Blood Testing

I acknowledge under Virginia law that if a health care provider, or any person employed by or under the direction and control of a health care provider, is directly exposed to my body fluids in a manner which may transmit human immunodeficiency virus (HIV) or Hepatitis B or C viruses, I will be deemed to have consented to testing for HIV or Hepatitis B or C viruses and to the release or disclosure of the test results to the person who was exposed to testing for infection with HIV. I understand that if I am exposed to a healthcare worker's body fluids they will be deemed to have consented to testing for HIV or Hepatitis B or C viruses and to the release or disclosure of the test results to me.

I am aware that if I do not fully understand any part of this form, I may ask a Bridgewater College health care professional to explain it before I sign it.

Signature of Student/Athlete

Date

Printed Name of Student/Athlete

Signature of Parent/Guardian*

**Needed if student/athlete is under 18 years of age.*

BRIDGEWATER COLLEGE

CERTIFICATE OF IMMUNIZATION

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. (All information must be in English).

In compliance with Virginia state law, Bridgewater College requires entering students to provide immunization documentation of the vaccines listed below before being allowed to participate in classes.

Name _____ Date of Birth _____
Last *First* *Middle*

Address _____

City _____ State _____ Zip _____ Term/Year of application _____

VACCINE	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	BOOSTER	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE
MMR	/ /	/ /			/ /
Varicella <small>(Before age 13)</small>	/ /	/ /			<small>(or history of varicella)</small> / /
Tetanus-Diphtheria Series <small>(Must also have current Tdap)</small>	/ / <small>(most recent date)</small>	/ /	/ /		/ /
Hepatitis B	/ /	/ /	/ /		
Polio	/ /	/ /	/ /	/ /	
Gardasil	/ /	/ /	/ /		

Meningitis Vaccine: Date received: _____ Menactra _____ Menomune _____

The risk of meningitis and meningococcal infection may be increased in some subsets of college students. Therefore, the state of Virginia requires all new, incoming full time residential students to receive the meningitis vaccine before final registration to classes.

Waiver must be signed if decision is made NOT to receive vaccine!

My physician has informed me of the risks associated with meningococcal disease and the benefits of receiving the vaccination. By signing below, I acknowledge being so informed, and that I choose not to be vaccinated against meningococcal disease.

Signature: _____ Date: _____
(To be signed by parent or guardian if student is a minor)

At the recommendation of the NCAA, Bridgewater College requires that all intercollegiate athletes must verify their sickle cell trait status prior to participation in a sport without regard to risk factors. Athletes will be unable to participate without this verification.

Sickle Cell Trait Positive: _____ Sickle Cell Trait Negative: _____ Date of test: _____

 Name of Health Care Provider *(Printed)* Signature Date

Tuberculosis Screening (Required of all students)

Name: _____ Date of Birth: _____

TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER

Based on the guidelines published by the American College Health Association, the recommendations from the Centers for Disease Control (CDC) and the American Thoracic Society, tuberculosis (TB) screening is required within six months of college entry primarily by conducting a Risk Assessment. For more information, visit www.acha.org or refer to the CDC's Core Curriculum on Tuberculosis available at state health departments or at the following website: <http://www.cdc.gov/tb/>.

Please answer the following questions. If the student is at low risk, a PPD is not required for entrance into college.

1. Does the student have **signs or symptoms of active TB disease?** YES NO

If **NO**, proceed to question 2.

If **YES**, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, chest X-ray and sputum evaluation as indicated by the Health Professional.

2. Is the student a member of a **high-risk group?** YES NO

Categories of high-risk students include those: with HIV infection; who inject drugs; who have resided in, volunteered in or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunioileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone \geq 15mg/d for \geq 1 month) or other immunosuppressive disorders.

If **NO**, continue to question 3

If **YES**, **place tuberculin skin test**

3. Has the student travelled (spent 6 weeks or more) in countries where TB is endemic? YES NO

Includes those students who have arrived within the past 5 years from countries other than those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia (USA), Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand.

IF NO to #1, #2, & #3, PPD and chest X-ray are not required. No further evaluation is required, please sign below.

IF YES, Students should undergo tuberculin skin test and/or chest X-ray.

PLEASE USE THE SPACE BELOW TO DOCUMENT TUBERCULIN SKIN TESTING AND/OR CHEST X-RAY *(Based on assessment criteria outlined above)*

A. Tuberculin Skin Test *(When indicated, TB skin testing must be administered and documented in the US after March 2009.)*

Date given: ___/___/___ Date read: ___/___/___ Result: _____ mm
Mo Day Yr Mo Day Yr

Interpretation *(based on mm of induration as well as risk factors)* Negative Positive

B. Chest X-ray **(required if Tuberculin Skin test is positive or if PPD has not been placed but patient is at risk of disease; must have been performed within past 6 months.)**

Date of chest X-ray: _____ Result: Normal Abnormal

INH Initiated Date _____ X _____ months

HEALTH CARE PROVIDER: *(Signature required as validation of correct information for immunizations and TB assessment)*

Name: _____ Address: _____

Signature: _____ Printed: _____

Phone: _____ Fax: _____ Date: _____

BRIDGEWATER COLLEGE

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Personal Information

Last Name	First Name	Middle Name	Height	Weight
Sport(s) if applicable		Class	Age	Date of Birth
Parent/Guardian's Name		Home Address	City/State/Zip	
Home Phone Number	Emergency Phone Number		Student's Cell Phone Number	

Insurance Information

Health Insurance Agency Name	
Policy Number	
Does your health insurance require pre-authorization for treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Medical Information

Family Physician Name	Family Physician Phone Number	
Check all that apply to your past medical history:		
<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart condition	<input type="checkbox"/> Regularly use prescription medications
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hernia/Rupture	<input type="checkbox"/> Serious bone/joint injury
<input type="checkbox"/> Asthma	<input type="checkbox"/> High/Low blood pressure	<input type="checkbox"/> Wear glasses
<input type="checkbox"/> Concussion	<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Wear contacts
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Regularly use nutritional supplements	
<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Regularly use over the counter medications	
List allergies to any medications:		
List previous surgeries and the dates they occurred:		
List all medications and nutritional supplements used:		
List previous injuries requiring hospitalization:		

Authorization for Emergency Medical Treatment

I hereby give my permission for emergency treatment to be provided to me for medical conditions or injuries resulting from my participation in athletics, or while on campus. This treatment may include but not be limited to first-aid, transportation to an emergency facility and other such procedures as the College's health care staff deem appropriate.

_____	_____	_____
Name (Printed)	Signature	Date
_____	_____	_____
**Parent/Guardian Name (Printed)	Parent/Guardian Signature	Date
<i>**Only to be completed if a student is under 18 years of age</i>		

Authorization for Release of Medical Information

I authorize Bridgewater College's health care employees, including Health Services, Counseling Services and Athletic Training staff, to release my confidential health records and information to (a) other College employees if disclosure is necessary for the employee to perform tasks related to his or her position, and (b) other health care providers involved in my care. I understand that the College may not condition treatment on my willingness to sign this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records already disclosed under this authorization. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected while solely in the possession of the College.

_____	_____	_____
Name (Printed)	Signature	Date
_____	_____	_____
**Parent/Guardian Name (Printed)	Parent/Guardian Signature	Date
<i>**Only to be completed if a student is under 18 years of age</i>		