Dear Luther College Athlete/Parent(s):

In anticipation of the upcoming athletic season this letter is to inform you and your parents of the requirements of Luther College which must be on file prior to the start of your participation in athletics. This packet will provide you with ALL information needed to make sure you have everything done and turned in when you arrive on campus. All athletes need a pre-participation physical examination prior to the start of the athlete’s season. Also required on file is information regarding insurance coverage, Sickle Cell Trait, Emergency Contact, and ADHD (if applicable).

Luther College requires all of its students to get an entrance physical before arriving on campus. As a student-athlete, you are ALSO required to get an athletic physical prior to the start of your season. When you go for your physical, please have the physician fill out BOTH the entrance physical and the athletic physical. If you have already done the entrance physical, please contact your doctor and ask them to transfer the information onto the athletic physical. Having only the entrance physical will not count. Need Athletic Physical for athletic participation! A medical doctor (M.D.), an osteopathic doctor (D.O.), or a physician assistant (P.A.) must sign off on the forms. Please have the doctor’s office stamp the form to verify it was performed by a licensed professional. Physical examinations should be performed after June 1st.

Another requirement for the student athlete is the Sickle Cell Trait form. The NCAA requires each athlete to show proof of their Sickle Cell trait status. All newborns are screened for sickle cell trait at time of birth, so by checking your newborn screening results, you will know your status. If unable to do this, there are 2 other options: get tested for sickle cell trait or waive the right to disclose. Waiving the right will result in secondary education session by the Luther College Athletic Training staff prior to participation. Further information is available on the form.

There are two online forms regarding Insurance Coverage and Emergency Contact information which must be filled out. They can be found at http://www.luther.edu/sports/resource/check-list/ and are #4 and #5 on the checklist.

The final requirement is to bring your insurance card with you on the day you check in. We will scan it and give it right back to you. If unable to bring the card, please have a copy of the front and back of your insurance card with you.

Please turn in the following forms to the Head Athletic Trainer (Athletes are NOT allowed to participate in sporting activity without these turned in):

- Entrance Physical (last 4 pages of the packet)
- Athletic Physical w/orthopedic exam (pages 2-5)
- Sickle Cell Trait Form signed and dated (If waived, need only athlete signature with date)
- 2 Online Forms Submitted using website above (Emergency Contact Form and Insurance Form)
- ADHD Form (if applicable)

Please turn in the completed and signed forms to: Amber Suckow
Head Athletic Trainer
Luther College
700 College Drive
Decorah, IA 52101

Please feel free to contact me with any questions or concerns. Thank you in advance for assisting in the process of preparing for the coming athletic season. ~ Amber Suckow MS, ATC
I, the undersigned herewith declare to the best of my knowledge, that the above questions have been answered truthfully and correctly and

A. Understand that I must refrain from practice or play during medical treatment until I am discharged from treatment or given a written permit by the attending physician to resume participation.

B. Understand that having completed the pre-participation screening process does not necessarily mean I am physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify me.

C. Understand that I cannot participate (practice or compete) until this form is signed by a Physician/Physician Assistant.

Student Athletes Signature ________________________________ Date __________________

---

Students participating in intercollegiate athletics must have a complete physical examination including orthopedic screening, up-to-date immunizations, and private health insurance information on file. A student-athlete who has sustained a significant injury or illness within the past 12 months must receive clearance from a physician before resuming participation in a varsity sport.

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Year in College</th>
<th>ID Number</th>
<th>Sport</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone Number</th>
<th>Luther Email</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Tetanus (must be within 10 years)
Are you CURRENTLY under the care of a physician for any chronic medical condition?  Yes  No
If yes, please indicate condition and treatment.

<table>
<thead>
<tr>
<th>Have you ever:</th>
<th>date</th>
<th>date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passed out during exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had chest pain during exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had a heart attack?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Been told you have a heart murmur?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had racing heart/skipping beats?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had heat exhaustion/heat stroke?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Been dizzy or passed out due to heat?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medications taken</th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td>High blood pressure</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Tire more quickly than your friends during exercise?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Smoke cigarettes (number per day: )</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Use smokeless tobacco</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Have more than 2 alcoholic drinks per week?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Have very irregular or absent periods?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Have diabetes?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Use eyeglasses/contact lenses/ protective eyewear?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Have you had mononucleosis recently?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Have you ever or are you currently being treated for any eating disorder?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Are you now receiving or have you ever received treatment or counseling for mental health illness or substance abuse?</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Weakness, pain, or swelling in any of the following?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
</tr>
<tr>
<td>Hand.</td>
</tr>
<tr>
<td>Wrist.</td>
</tr>
<tr>
<td>Forearm</td>
</tr>
<tr>
<td>Elbow</td>
</tr>
<tr>
<td>Back.</td>
</tr>
</tbody>
</table>

Must you use special equipment for completion (pads, braces, neck roll, etc.)?  Yes  No
If yes, please explain:

Sickle cell status:  positive  negative  unknown/waived
If Unknown/waived: I have completed the 2<sup>nd</sup> Education sessions.  Yes  No

Are you currently taking any medications (birth control, prescriptions meds, vitamins, aspirin, etc.):

Are you currently taking performance enhancement supplements (creatine, etc.):

Please list any allergies you may have (medicine, bees, food, etc.):

<table>
<thead>
<tr>
<th>Allergies</th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please list any allergies you may have:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

LUTHER COLLEGE VARSITY ATHLETIC PHYSICAL
Participation History – To be completed by the Student Athlete
Pre PARTICIPATION MEDICAL SCREEN
TO BE COMPLETED BY PHYSICIAN/PHYSICIAN ASSISTANT

PHYSICAL EXAMINATION

Height without Shoes _________________ Weight ____________________ Blood Pressure _____________ Pulse____________

Vision: ☐ Corrected lenses ☐ Uncorrected Left eye: ___________________ Right eye: ___________________

I have reviewed the medical history with this student-athlete ☐ Yes ☐ No

Is there any medical history or an injury or illness within the past 12 months which might limit full participation in a varsity sport? ☐ Yes ☐ No

If yes, state reason_____________________________________________________________________________________________________________________________________

TO BE COMPLETED BY PHYSICIAN

Normal Abnormal Describe findings, please refer to item number
☐ 1. Head …………………………………… ☐ ☐ ______________________________________________________
☐ 2. Eyes (pupils), ENT…………… ☐ ☐ ______________________________________________________
☐ 3. Teeth ……………………………… ☐ ☐ ______________________________________________________
☐ 4. Chest ……………………………… ☐ ☐ ______________________________________________________
☐ 5. Lungs ……………………………… ☐ ☐ ______________________________________________________
☐ 6. Heart ……………………………… ☐ ☐ ______________________________________________________
☐ 7. Abdomen……………………. ☐ ☐ ______________________________________________________
☐ 8. Neurologic …………………. ☐ ☐ ______________________________________________________
☐ 9. Skin ………………………….. ☐ ☐ ______________________________________________________
☐ 10. Physical Maturity ……….. ☐ ☐ ______________________________________________________

ASSESSMENT

☐ Full Participation/Cleared
☐ Limited Participation (describe limitations, restrictions) ______________________________________________________

☐ No Clearance (list reasons) ______________________________________________________

Recommendations ______________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Physician’s Signature ______________________________________________________Date ______________________

Physician’s Name (printed) __________________________________________________________________________________
**Orthopedic Screening Examination Form**
*To be completed by Physician, Physician Assistant, or Certified Athletic Trainer*

Name ___________________________________________ Sport ____________________________

<table>
<thead>
<tr>
<th>Section</th>
<th>History of Injury</th>
<th>ROM/Flexibility</th>
<th>Strength</th>
<th>Laxity/Instability</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ankle/Foot:</strong></td>
<td>□ YES □ NO</td>
<td>Please Describe</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Knee:</strong></td>
<td>□ YES □ NO</td>
<td>Please Describe</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hip/Thigh:</strong></td>
<td>□ YES □ NO</td>
<td>Please Describe</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Low Back:</strong></td>
<td>□ YES □ NO</td>
<td>Please Describe</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Shoulder:</strong></td>
<td>□ YES □ NO</td>
<td>Please Describe</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Elbow:
- **History of Injury**: [ ] YES  [ ] NO
  - Please Describe
- **ROM/Flexibility**: 
- **Strength**: 
- **Laxity/Instability**: 
- **Recommendations**: 

## Wrist/Hand:
- **History of Injury**: [ ] YES  [ ] NO
  - Please Describe
- **ROM/Flexibility**: 
- **Strength**: 
- **Laxity/Instability**: 
- **Recommendations**: 

## Cervical Spine:
- **History of Injury**: [ ] YES  [ ] NO
  - Please Describe
- **ROM/Flexibility**: 
- **Strength**: 
- **Neurovascular**: 
- **Recommendations**: 

## Other:
- **History of Injury**: [ ] YES  [ ] NO
  - Please Describe
- **Head Trauma / Concussion Hx**: 
- **Recommendations**: 

## Recommendations / Comments:

---

## Status:
- [ ] Pass without restrictions
- [ ] Pass with restrictions
- [ ] Further Evaluation Needed
  - Appt. with ___

---

**Student-Athlete’s Signature** ____________________________ **Date**

**Examining Physician’s or ATC Signature** ____________________________ **Date**

**Athletic Training Student Initials**
**Sickle Cell Trait Policy**

Per NCAA guidelines, all student-athletes are required to show proof of sickle cell trait status; testing and results prior to sport participation. Please read the following statement from the NCAA and return the completed form to the Luther College Athletic Training Staff.

**Background:** Sickle cell trait is not a disease, but a life-long condition from the inheritance of one gene for sickle hemoglobin and one for normal hemoglobin. During intense exercise, red blood cells containing the sickle hemoglobin can change shape and may accumulate in the bloodstream blocking normal blood flow to the tissues and muscles. **Athletes with sickle cell trait have experienced significant physical distress, collapsed and even died.** Heat, dehydration, altitude and asthma can increase the risk for and worsen complications associated with sickle cell trait, even when exercise is not intense. Athletes with sickle cell trait should not be excluded from participation as precautions can be put into place.

**NCAA Guidelines:** Prior to participation in any practice, competition, or out-of-season conditioning activities the following need to be administered or collected on all student-athletes:

- **Confirmation of Sickle Cell Trait Status.** An institution shall confirm the sickle cell trait status of student-athletes, before participation in intercollegiate athletics in one of the following manners:
  1) **Documentation.** The student-athlete may provide documented results of a sickle cell solubility test administered prior to participation.
  2) **Pending Documentation.** A student-athlete who has taken a sickle cell solubility test, but whose results are not yet confirmed, may participate provided the student-athlete engages in mandatory education as set forth in Bylaw 17.1.6.4.1.1 and receives appropriate precautions as set forth by the institution; or
  3) **Waiver.** The student-athlete may sign a waiver declining confirmation of sickle cell trait status if:
     - Prior to signing a waiver, the institution provides the student-athlete education regarding the implications of exercising the waiver option; and
     - Prior to athletics participation, a student-athlete who signs a waiver under this provision engages in mandatory education as set forth in Bylaw 17.1.6.4.1.1.
     - 17.1.6.4.1.1 Mandatory Sickle Cell Trait Status Education. Each student-athlete shall be provided education regarding sickle cell trait status. Student-athletes who have been tested, but do not have confirmed results documented or have signed a waiver per Bylaw 17.1.6.4.1(c), shall be provided additional education regarding the risks, impact and precautions associated with sickle cell trait.

***You have been screened for the sickle cell trait as a newborn. Check your newborn screens for hemoglobinopathy results. Take the screening results in with you to your general physician and have him/her sign the form.****
Please print off and take to your physician for verification on whether you have been tested for sickle cell trait.

Please return completed form to:
Attn: Athletic Training
Luther College
700 College Drive
Decorah, IA 52101

Athlete Name: ________________________________  Sport(s) ________________________________

Check the appropriate box below:

☐ Yes, I have been tested and I DO have sickle cell trait.
   Date of Results: ________________________________

☐ Yes, I have been tested and do NOT have sickle cell trait
   Date of Results: ________________________________

☐ No, I have NOT been tested for sickle cell trait but I’m in the process.
   Date Being Tested: ________________________________

☐ I choose not to respond and waive this question. *(Further education will be required)*

Physician Signature: ________________________________  Date: ________________________

Athlete Signature: ________________________________  Date: ________________________

***You have been screened for the sickle cell trait as a newborn. Check your newborn screens for hemoglobinopathy results. Take the screening results in with you to your general physician and have him/her sign the form.****
NCAA Medical Exception Documentation Reporting Form
For Attention Deficit Hyperactivity Disorder and Medications

Purpose of this form is (only if applicable):

- To support the diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and treatment with Banned Stimulant Medication
- Complete and maintain (on file in the Luther College Athletic Training Department) this form and required documentation supporting the medical need for a student-athlete to be treated for ADHD with stimulant medication.
  - Submit this form and required documentation to Drug Free Sport in the event the student-athlete tests positive for the banned stimulant (see Drug Testing Exceptions Procedures at www.ncaa.org/drugtesting).

To be completed by the Student-Athlete’s Physician

Treating Physician (print name): ____________________________________________
Specialty: ______________________________________________________________
Office address: ___________________________________________________________
Physician signature: ______________________________________________________ Date: __________________

Required Physician documentation (letter, medical notes) to include the following information – Please attach written report that includes the following information:

- The type of documentation required by the NCAA is defined as follows: “The institution should keep on file a record of the student-athlete’s evaluation, diagnosis, the history of treatment, and a copy of the most recent prescription. This documentation can be compiled in the form of a dictated letter from the prescribing physician if the letter includes the details previously mentioned. There is no need to keep records of all testing, but rather to demonstrate that an evaluation has been conducted to achieve the diagnosis.”
  - Diagnosis.
  - Medication(s) and dosage.
  - Blood pressure and pulse readings and comments.
  - Note that alternative non-banned medications have been considered, and comments.
  - Follow-up orders.
  - Date of clinical evaluation:
  - Attach written report summary of comprehensive clinical evaluation:
    - The evaluation should include individual and family history, address any indication of mood disorders, substance abuse, and previous history of ADHD treatment, and incorporate the DSM criteria to diagnose ADHD. Attach supporting documentation, such as completed ADHD Rating Scale(s) (e.g., Connors, ASRS, CAARS) scores.
    - The evaluation can and should be completed by a clinician capable of meeting the requirements detailed above.

Note: The physician documentation is required. If the student-athlete does not provide this information, he/she will not be considered exempt should they test positive for ADHD medications and the drug testing policy will be enforced.

DISCLAIMER: The National Collegiate Athletic Association shall not be liable or responsible, in any way, for any diagnosis or other evaluation made, or exam performed, in connection herewith, or for any subsequent action taken, in whole or in part, in reliance upon the accuracy or veracity of the information provided hereunder.
Student Health Evaluation Form

RETURN THIS FORM BY THE AUGUST 1 DEADLINE TO
Health Service, Luther College, 700 College Drive, Decorah, Iowa 52101

TO THE STUDENT
Luther College requires all students to complete this form as part of admission. Return this form prior to August 1.
Before visiting your health care provider, complete all of pages 1 and 2. Your health care provider should complete pages 3 and 4.

You have been offered admission to Luther College. All information on these pages is considered confidential and protected information and will not be used to influence your situation at the college.

Date of entry to Luther (month/year) _______ _______  Entering as: _ Freshman _ Transfer

Visiting your health care provider, complete all of pages 1 and 2. Your health care provider should complete pages 3 and 4.

Student Health Evaluation Form

IDENTIFICATION
(please complete the entire form in black ink.)

NAME
Last Name (family) _______ First Name (given) _______ Middle _______

HOME ADDRESS
Street _______ City _______ State _______ ZIP _______

COMMUNITY ADDRESS
Street _______ City _______ State _______ ZIP _______

CONTACT INFORMATION
Home Telephone (with area code) _______ Cell Telephone (with area code) _______

FAMILY HISTORY

FATHER
Great Name _______ Age _______ Occupation _______ Age of Death _______ Cause of Death _______

MOTHER
Great Name _______ Age _______ Occupation _______ Age of Death _______ Cause of Death _______

Person’s Name _______ Relationship _______

FAMILY HISTORY

WESTERN MARKER CONDITIONS

Do you have any of the following conditions? Yes No

1. Head Injury with Unconsciousness
2. Headache, Migraine
3. Back Problems
4. Menstrual Irregularity (female)
5. Kidney Disease
6. Diabetes
7. Heart Disease
8. Blindness
9. Hearing Impairment
10. Mental Health Disorder
11. Seizures

CONTACT INFORMATION

Social Security Number _______ Date of Birth _______

PERSONAL MEDICAL HISTORY

Have you ever been diagnosed with any of the following conditions? Yes No

1. Heart Disease
2. Diabetes
3. Hypertension
4. Epilepsy
5. Cancer
6. Mental Health Disorder
7. Seizures

MEDICAL ALERT CONDITIONS

Identify any medical issues (e.g., the use of life-saving medication) that need to be known in an emergency.

MEDICAL ALERT CONDITIONS

MUST BE COMPLETED WITHIN 12 MONTHS PRIOR TO COLLEGE ENTRANCE

Physical Examination by Health Care Provider

EXAMINATION

Normal Abnormal

Abnormal Findings (numbered and noted):

1. General Appearance _______ _______
2. Skin _______ _______
3. Head / Face _______ _______
4. Eyes _______ _______
5. Ears _______ _______
6. Nose & Sinuses _______ _______
7. Throat _______ _______
8. Neck _______ _______
9. Throat _______ _______
10. Breasts _______ _______
11. Lungs _______ _______
12. Heart _______ _______
13. Abdomen _______ _______
14. Genitalia _______ _______
15. Rectal _______ _______
16. Musculoskeletal _______ _______
17. Lymphatics _______ _______
18. Blood Vessels _______ _______
19. Neurological _______ _______
20. Psychological _______ _______
21. Depression _______ _______
22. Anxiety _______ _______
23. Eating Disorder _______ _______

STUDENT ATHLETES ONLY

OPTIONAL

Sickle Cell trait status _______ _______

Screening Questions for Student

Yes No

1. Do you have allergies to medications?
2. Are you currently receiving treatment for mental health illness or substance abuse?
3. Have you had any serious illness or injury or been hospitalized other than already noted?
4. Are you currently engaged in regular exercise?
5. Do you use alcohol/other drugs?
6. Do you smoke?

SCREENING QUESTIONS FOR STUDENT

you have any of the following conditions? Yes No

Examination by Health Care Provider

Recommendations for treatment, restriction of academic load or physical activity. Please include period of time for restriction and comments on history.

I find no medical reason to disqualify _______ _______ from participation in athletics.

If disqualified, please explain: _______ _______

Student’s Name _______

Recommendations for treatment, restriction of academic load or physical activity. Please include period of time for restriction and comments on history.

Phone number _______ FAX number _______

Information disclosed on this form is not released to or shared with other offices on campus.

Students: Upon completion of your forms, mail to Health Service, Luther College, 700 College Drive, Decorah, IA 52101.

Physical Examination by Health Care Provider

MUST BE COMPLETED WITHIN 12 MONTHS PRIOR TO COLLEGE ENTRANCE

IDENTIFICATION

(please complete the entire form in black ink.)

NAME
Last Name (family) _______ First Name (given) _______ Middle _______

HOME ADDRESS
Street _______ City _______ State _______ ZIP _______

COMMUNITY ADDRESS
Street _______ City _______ State _______ ZIP _______

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Home Telephone (with area code) _______ Cell Telephone (with area code) _______

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FATHER
Great Name _______ Age _______ Occupation _______ Age of Death _______ Cause of Death _______

MOTHER
Great Name _______ Age _______ Occupation _______ Age of Death _______ Cause of Death _______

Person’s Name _______ Relationship _______

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3. Back Problems
4. Menstrual Irregularity (female)
5. Kidney Disease
6. Diabetes
7. Heart Disease
8. Blindness
9. Hearing Impairment
10. Mental Health Disorder

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8. Neck _______ _______
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10. Breasts _______ _______
11. Lungs _______ _______
12. Heart _______ _______
13. Abdomen _______ _______
14. Genitalia _______ _______
15. Rectal _______ _______
16. Musculoskeletal _______ _______
17. Lymphatics _______ _______
18. Blood Vessels _______ _______
19. Neurological _______ _______
20. Psychological _______ _______
21. Depression _______ _______
22. Anxiety _______ _______
23. Eating Disorder _______ _______

STUDENT ATHLETES ONLY

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Screening Questions for Student

Yes No

1. Do you have allergies to medications?
2. Are you currently receiving treatment for mental health illness or substance abuse?
3. Have you had any serious illness or injury or been hospitalized other than already noted?
4. Are you currently engaged in regular exercise?
5. Do you use alcohol/other drugs?
6. Do you smoke?

SCREENING QUESTIONS FOR STUDENT

you have any of the following conditions? Yes No

Examination by Health Care Provider

Recommendations for treatment, restriction of academic load or physical activity. Please include period of time for restriction and comments on history.

I find no medical reason to disqualify _______ _______ from participation in athletics.

If disqualified, please explain: _______ _______

Student’s Name _______

Recommendations for treatment, restriction of academic load or physical activity. Please include period of time for restriction and comments on history.

Phone number _______ FAX number _______

Information disclosed on this form is not released to or shared with other offices on campus.

Students: Upon completion of your forms, mail to Health Service, Luther College, 700 College Drive, Decorah, IA 52101.
Meningococcal disease is a potentially life-threatening bacterial infection caused by Neisseria meningitidis, a leading cause of bacterial meningitis in older children and adults. Studies suggest that up to 80 percent of college cases are vaccine preventable. For additional information, go to www.luther.edu/healthservice/immunizations/ meningo.html.

If a serious illness or accident should occur, and there is concern for the student’s safety, every effort will be made to contact parents or guardian. However, in the event that delay in medical or surgical treatment may be detrimental to the health of the student, authorization for consultation and treatment by area physicians is requested. Luther College Health Service recognizes the importance of cooperating with the student’s family physician, clinic, or hospital in providing health care while the student is enrolled in college. In order to secure or exchange health information, it is necessary to have the permission of the student or parent/guardian if the student is under 18. On occasion, information regarding physical or mental health status of a student may be shared with the vice president for student life or counseling staff if there is a concern for the student’s immediate safety or the safety of others. No information will be provided to faculty or work study supervisors without specific consent of the student. Due to new federal regulations regarding confidentiality, additional consents regarding health information will need to be signed at the time the student is seen in Health Service.

Permission is hereby granted to share health information with my family physician, clinic, hospital, vice president for student life, or counseling staff if there is a concern for my immediate safety or the safety of others.

Informed Consent

I have read the above information on meningococcal disease, recommendations, and vaccination.☐ I have received the meningococcal vaccine. See above.☐ I decline the vaccination.

Please attach a copy of the back of your insurance card here.
Meningococcal disease is a potentially life-threatening bacterial infection caused by Neisseria meningitidis, a leading cause of bacterial meningitis in older children and young adults in the United States. The disease most commonly is expressed as either meningococcal meningitis, an inflammation of the membranes surrounding the brain and spinal cord, or meningococcemia, a serious infection of the blood.

Since 1991, cases of meningococcal disease among 15- to 24-year-olds have increased. Studies show that students residing in on-campus dormitories, especially first-year students, appear to be at up to a six-fold increase risk for meningococcal meningitis, an inflammation of the membranes surrounding the brain and spinal cord, or meningococcemia, a serious infection of the blood.

Since 1991, cases of meningococcal disease among 15- to 24-year-olds have increased. Studies show that students residing in on-campus dormitories, especially first-year students, appear to be at up to a six-fold increase risk for meningococcal meningitis, an inflammation of the membranes surrounding the brain and spinal cord, or meningococcemia, a serious infection of the blood.

**MENINGOCOCCAL VACCINATION**

Meningococcal disease is a potentially life-threatening bacterial infection caused by Neisseria meningitidis, a leading cause of bacterial meningitis in older children and young adults in the United States. The disease most commonly is expressed as either meningococcal meningitis, an inflammation of the membranes surrounding the brain and spinal cord, or meningococcemia, a serious infection of the blood. Since 1991, cases of meningococcal disease among 15- to 24-year-olds have increased. Studies show that students residing in on-campus dormitories, especially first-year students, appear to be at up to a six-fold increase risk for meningococcal disease than college students overall.

Vaccination: Two vaccinations are available against four of the most common strains of N. meningitidis in the United States (A, C, Y, W-135). The vaccines are 85–90 percent effective in preventing disease in older children and adults. Studies suggest that up to 80 percent of college cases are vaccine preventable.

For additional information, go to www.luther.edu/healthservice/immunizations/meningococcal:

- I have received the meningococcal vaccine. See above.
- I decline the vaccination.

Meningooccal vaccine must be given within 12 months of enrollment. It is recommended that meningococcal vaccine be given as early as possible in the student’s academic career.

**RECOMMENDED IMMUNIZATIONS**

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Month/Year</th>
<th>Age</th>
<th>Route</th>
<th>Finish</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meningococcal*</td>
<td>10/2013</td>
<td>2</td>
<td>IM</td>
<td></td>
</tr>
<tr>
<td>HEPATITIS A</td>
<td>10/2013</td>
<td>1</td>
<td>IM</td>
<td></td>
</tr>
<tr>
<td>HEPATITIS B (Infectious)</td>
<td>10/2013</td>
<td>1</td>
<td>IM</td>
<td></td>
</tr>
<tr>
<td>VARICELLA</td>
<td>10/2013</td>
<td>1</td>
<td>IM</td>
<td></td>
</tr>
<tr>
<td>INFLUENZA</td>
<td>10/2013</td>
<td>1</td>
<td>IM</td>
<td></td>
</tr>
<tr>
<td>HPV</td>
<td>10/2013</td>
<td>1</td>
<td>IM</td>
<td></td>
</tr>
<tr>
<td>TYPHOID</td>
<td>10/2013</td>
<td>1</td>
<td>IM</td>
<td></td>
</tr>
<tr>
<td>YELLOW FEVER</td>
<td>10/2013</td>
<td>1</td>
<td>IM</td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td>10/2013</td>
<td>1</td>
<td>IM</td>
<td></td>
</tr>
</tbody>
</table>

**VACCINATION RECORD**

Attach a copy of the front and back of your insurance card here.

Please attach a copy of the front of your insurance card here.

Please attach a copy of the back of your insurance card here.
Physical Examination by Health Care Provider

**Recommendations for treatment, restriction of academic load or physical activity. Please include period of time for restriction and comments on history.**

If disqualified, please explain:

**Health Care Provider’s Name (printed) Health Care Provider’s Signature Date**

### EXAMINATION

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal (as noted or suspected)</th>
<th>Abnormal Findings (numbered and noted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. General Appearance □ □</td>
<td>□ □</td>
<td>□ □</td>
</tr>
<tr>
<td>2. Skin</td>
<td>□ □</td>
<td>□ □</td>
</tr>
<tr>
<td>3. Head / Face</td>
<td>□ □</td>
<td>□ □</td>
</tr>
<tr>
<td>4. Eyes</td>
<td>□ □</td>
<td>□ □</td>
</tr>
<tr>
<td>5. Ears</td>
<td>□ □</td>
<td>□ □</td>
</tr>
<tr>
<td>6. Nose &amp; Sinuses</td>
<td>□ □</td>
<td>□ □</td>
</tr>
<tr>
<td>7. Mouth / Throat</td>
<td>□ □</td>
<td>□ □</td>
</tr>
<tr>
<td>8. Neck</td>
<td>□ □</td>
<td>□ □</td>
</tr>
<tr>
<td>9. Thorax</td>
<td>□ □</td>
<td>□ □</td>
</tr>
<tr>
<td>10. Breasts</td>
<td>□ □</td>
<td>□ □</td>
</tr>
<tr>
<td>11. Lungs</td>
<td>□ □</td>
<td>□ □</td>
</tr>
<tr>
<td>12. Heart</td>
<td>□ □</td>
<td>□ □</td>
</tr>
<tr>
<td>13. Abdomen</td>
<td>□ □</td>
<td>□ □</td>
</tr>
<tr>
<td>14. Genitalia</td>
<td>□ □</td>
<td>□ □</td>
</tr>
<tr>
<td>15. Rectal</td>
<td>□ □</td>
<td>□ □</td>
</tr>
<tr>
<td>16. Musculoskeletal</td>
<td>□ □</td>
<td>□ □</td>
</tr>
<tr>
<td>17. Lymphatics</td>
<td>□ □</td>
<td>□ □</td>
</tr>
<tr>
<td>18. Blood Vessels</td>
<td>□ □</td>
<td>□ □</td>
</tr>
<tr>
<td>19. Neurological</td>
<td>□ □</td>
<td>□ □</td>
</tr>
<tr>
<td>20. Psychological</td>
<td>□ □</td>
<td>□ □</td>
</tr>
<tr>
<td>21. Depression</td>
<td>□ □</td>
<td>□ □</td>
</tr>
<tr>
<td>22. Anxiety</td>
<td>□ □</td>
<td>□ □</td>
</tr>
<tr>
<td>23. Eating Disorder</td>
<td>□ □</td>
<td>□ □</td>
</tr>
</tbody>
</table>

I find no medical reason to disqualify, _______ from participation in athletics. If disqualified, please explain: ________

**Student Health Evaluation Form**

RETURN THIS FORM BY THE AUGUST 1 DEADLINE TO

Health Service, Luther College, 700 College Drive, Decorah, IA 52101

TO THE STUDENT

Luther College requires all students to complete this form as part of admission. Return this form prior to August 1.

Before visiting your health care provider, complete all of pages 1 and 2. Your health care provider should complete pages 3 and 4.

You have been offered admission to Luther College. All information on these pages is considered confidential and protected information and will not be used to influence your situation at the college.

Date of entry to Luther (month/year) _______ _______ Entering as ______ First-year student ______ Transfer ______

I have read and understood the information on this form.

**Student Name**

**Social Security Number**

**Date of Birth**

**Home Address**

**City**

**State**

**Zip**

**Home Telephone** (with area code)

**Cellular Telephone** (with area code)

**Country**

**Gender** (optional)

**City**

**State**

**ZIP**

**Home Address of Person to Notify**

**Name and Relationship**

**Event that must be recorded, whether a checked frequently?**

**Student Cellular Telephone** (with area code)

**Date of Birth**

**Student Health Evaluation Form**

**Health Service, Luther College, 700 College Drive, Decorah, IA 52101**

**Student Name**

**Social Security Number**

**Date of Birth**

**Home Address**

**City**

**State**

**Zip**

**Home Telephone** (with area code)

**Cellular Telephone** (with area code)

**Country**

**Gender** (optional)

**City**

**State**

**ZIP**

**Home Address of Person to Notify**

**Name and Relationship**

**Event that must be recorded, whether a checked frequently?**

**Student Cellular Telephone** (with area code)

**Date of Birth**

**Student Health Evaluation Form**

**Identification**

(please complete the entire form in black ink.)

- **Last Name (family) First Name (given) Middle**
- **Home Address**
- **City**
- **State**
- **ZIP**
- **Home Telephone** (with area code)
- **Cellular Telephone** (with area code)
- **Social Security Number**
- **Date of Birth**

**Notifying in emergency**

(own phone numbers listed)

- **Name and Relationship**
- **Home Address of Person to Notify**
- **Cellular Telephone** (with area code)
- **Home Telephone** (with area code)

**Medical alert conditions**

- **List medication allergies:**
- **List other allergies:**

**Personal medical history**

- **I have this “med-alert” condition:**
- **Do you have any genetic, chemical or other allergies?**
- **Do you smoke?**
- **Do you use any other drugs?**

**Student athletes only**

**OPTIONAL**

- **Sickle cell trait status**
- **Vision screening**
- **Hgb/Hct**
- **Cholesterol**
- **Urnalysis**

**STUDENT ATHLETES ONLY**

- **List other conditions:**
- **List other allergies:**

**Screening questions for student**

- **Yes**
- **No**

1. Do you have physical or learning limitations? □ □
2. Are you currently taking any prescribed medications or medications for mental health illness or substance abuse? □ □
3. Have you had any serious illness or injury or been hospitalized other than already noted? □ □
4. Are you taking any medications regularly? (Please list in the right column.) □ □
5. Do you currently engage in regular exercise? □ □
6. Do you consider your weight to be in a healthy range? □ □
7. Have you travelled outside your native country in the past 12 months? If so, where? □ □

- **Comment on invis, include dates, to the right:**

Information disclosed on this form is not released to or shared with other offices on campus.

Students are asked to complete the Student Health Evaluation Form and mail it to Health Service, Luther College, 700 College Drive, Decorah, IA 52101.