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):

_____ 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)
_____ Entrance Physical (last 4 pages of the packet)

_____ Return 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
**LUTHER COLLEGE VARSITY ATHLETIC PHYSICAL**

**Participation History – To be completed by the Student Athlete**

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.

Name ____________________________________________________________________________ Date of Birth _____/_____/_____ Year in College: 1 2 3 4

ID Number ___________________________ Sport ___________________________

Phone Number: (_____) _______ - __________ Luther Email: ________________________________

Tetanus (must be within 10 years) __________________________________________________________________________________________________________

A. Are you CURRENTLY under the care of a physician for any chronic medical condition?  Yes  No If yes, please indicate condition and treatment. ________________________________

B. Have you or are you currently taking any medications (birth control, prescriptions meds, vitamins, aspirin, etc.):  

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

<table>
<thead>
<tr>
<th>Do you:</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have high blood pressure?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tire more quickly than your friends during exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoke cigarettes? (number per day: ___)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wear eyeglasses/contact lenses/ protective eyewear?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have diabetes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have very irregular or absent periods?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have more than 2 alcoholic drinks per week?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have more than one paired organ? (eye, kidney testicle)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Have you had mononucleosis recently?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever or are you currently being treated for an eating disorder?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are you missing one of any paired organ? (eye, kidney testicle)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Wear eyeglasses/contact lenses/ protective eyewear?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Must you use special equipment for completion (pads, braces, neck roll, etc.)?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have weakness, pain, or swelling in any of the following?</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arm...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ankle...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrist...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Should...</td>
<td></td>
<td></td>
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<tr>
<td>Neck...</td>
<td></td>
<td></td>
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<tr>
<td>Thigh...</td>
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<tr>
<td>Foot...</td>
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<tr>
<td>Elbow...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kne...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back...</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If yes, please explain:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sickle cell status:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td></td>
</tr>
<tr>
<td>Unknown/waived</td>
<td></td>
</tr>
</tbody>
</table>

If Unknown/waived: I have completed the 2nd Education sessions. Yes No

___ \_ \_ \_

Are you missing one of any paired organ? (eye, kidney testicle) Yes No

If yes, please explain: ________________________________________________________________

If Unknown/waived: I have completed the 2nd Education sessions. Yes No

___ \_ \_ \_

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 ____________________
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 Sport 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

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

### Wrist/Hand:
<table>
<thead>
<tr>
<th>History of Injury</th>
<th>YES</th>
<th>NO</th>
<th>Please Describe</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROM/Flexibility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strength</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laxity/Instability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendations</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Cervical Spine:
<table>
<thead>
<tr>
<th>History of Injury</th>
<th>YES</th>
<th>NO</th>
<th>Please Describe</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROM/Flexibility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strength</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurovascular</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Recommendations</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Other:
<table>
<thead>
<tr>
<th>History of Injury</th>
<th>YES</th>
<th>NO</th>
<th>Please Describe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head Trauma / Concussion Hx</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendations</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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.
Your Healthcare provider will need to complete and sign your entrance physical on page 4.

You have been offered admission to Luther College. All information on these pages is considered confidential and protected information and has no effect on your admission status.

Date of entry to Luther (month/year) ___________________ Entering as: ☐ First-year student ☐ Transfer

IDENTIFICATION (Please complete the entire form in black ink)

Last Name (family) First Name (given) Middle
Home Address
City State ZIP
Country Gender (optional)

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

Social Security Number Date of Birth

FAMILY HISTORY

<table>
<thead>
<tr>
<th>Given Name</th>
<th>Age</th>
<th>Occupation</th>
<th>Age of Death</th>
<th>Cause of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Siblings (list separately)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have any of your relatives (parents/grandparents/sibling) had/have?

<table>
<thead>
<tr>
<th>Disease</th>
<th>Yes</th>
<th>No</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Trait</td>
<td></td>
<td></td>
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<tr>
<td>Tuberculosis</td>
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<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Kidney Disease</td>
<td></td>
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<td></td>
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<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Asthma/Hay Fever</td>
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<td></td>
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<tr>
<td>Seizure Disorder</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Mental Health Disease</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Substance Abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MEDICAL ALERT CONDITIONS

I have this “Med-Alert” Condition:

Ongoing chronic Illnesses:

List medication allergies:

List other allergies:

PERSONAL MEDICAL HISTORY

Answer all questions; comment on all positive answers.

Have you had? Yes No

- Headache, Migraine
- Head Injury with Unconsciousness
- Seizure Disorder
- Eye Disease
- Ear, Nose, Throat Disease
- Heart Disease
- Asthma
- Hay Fever/Seasonal Allergies
- High Blood Pressure
- Heart Murmur
- Rheumatic Fever
- Anemia
- Hemophilia
- Diabetes
- Gastrointestinal disease
- Recurrent Diarrhea
- Gall Bladder Disease
- Hernia
- Urinary Tract Infection

If so where?

Comment on all positive answers, include dates, below.

Information disclosed on this form is not released to or shared
With other offices on campus.
Confidential Sharing Agreement and Consent For Treatment

The college assures that medical information will be regarded as confidential and shared only as necessary for the student’s immediate safety. Health Service will not release medical information to parents unless the student signs a separate release of information specific to each illness/incident.

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 recognized 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.

_________________________________________________________________________________________________
Signature of Student       Date
________________________________________________________________________________________
Signature of parent/guardian (only needed if student is under age 18)    Date

HEALTH INSURANCE

Luther College recommends that students be covered by health insurance and carry an insurance card with them. If you do not have insurance coverage, check with insurance companies in your area. If you would like to obtain coverage from a Decorah-area company, visit www.luther.edu/healthservice/insurance for some options. Please make sure your insurance will extend to this area of the country. If you belong to an HMO, be aware of restrictions on medical or pharmaceutical service provided outside your HMO area. Health Service does not direct bill or participate with any insurance companies.

<table>
<thead>
<tr>
<th>Policy Holder Name</th>
<th>Policy Holder Birthdate</th>
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<tr>
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</table>

<table>
<thead>
<tr>
<th>Policy Holder Address</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy Holder Employer</th>
<th>Policy Holder</th>
<th>mother</th>
<th>father</th>
<th>self</th>
<th>other</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

ATTACH A COPY of the front and back of your insurance card.

See attachment areas for insurance card images.

Tuberculosis Screening

In compliance with the American College Health Association’s guidelines, Luther College requires TB screening and potential TB testing for all students that are identified as high risk. Please complete the Tuberculosis Screening Form and return with the Student Health Evaluation Form.
NOTICE: The remainder of this Student Health Evaluation Form requires an appointment with your health care provider. If your health care provider does not have a complete immunization record and you attended school in the United States, you can obtain the records from your school.

TO THE HEALTH CARE PROVIDER: Measles, Mumps, and Rubella – Two doses required for all students born after December 31, 1956 with dose #1 given at age 12 months or later and dose #2 given at least 28 days after first dose. Lab titers can be done for Rubeola if immunity is questioned.

### REQUIRED IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Month/Day/Year</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
<th>#4</th>
<th>#5</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR</td>
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<tr>
<td>DTP</td>
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<td>POLIO</td>
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<tr>
<td>TD or Tdap</td>
<td>within 10 years</td>
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</tr>
<tr>
<td>Menengitis Vaccine</td>
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</tbody>
</table>

**IMPORTANT MESSAGE TO STUDENTS**

Luther College requires that all students have a current health history, physical, and record of immunizations on file in the Student Health Service Office. Students not in compliance will experience an administrative hold placed on further registration. It is mandatory that you enter your own immunizations online: Please include an electronic hard copy of your immunizations with this form. Go to [luther.medicatconnect.com](http://luther.medicatconnect.com). Use the Norsekey sign-on and password that you received from Luther to log in.

**CONSCIENTIOUS/RELIGIOUS EXEMPTION MUST BE NOTARIZED. USE IMMUNIZATION WAIVER FORM FOR NOTARIZATION.**

I hereby certify by notarization that my conscientious or religious belief is opposed to immunizations.

Student Signature (or parent or legal guardian if under 18 years of age)

**MEDICAL EXemption**

Must also complete and include immunization waiver form from our website if unable to meet required immunizations due to medical contraindications. The physical condition of the above-named person is such that immunization would endanger life or health, or is medically contraindicated due to other medical conditions.

Signature of Medical Professional

Date

**USE IMMUNIZATION WAIVER FORM FOR NOTARIZATION FROM OUR WEBSITE.**

---

## REQUIRED TB SCREENING FOR INTERNATIONAL STUDENTS ONLY

(Required Tuberculosis Screening test will be completed at Luther Health Service)

**TSPOT**

Date collected: ______/______/______

Time collected: _____ a.m. p.m.

Result Date: ______/______/______ Results: □ Positive □ Negative

Mo. Day Year

Chest x-ray (if TSPOT positive) Results: □ Normal □ Abnormal

Date of Chest x-ray: ______/______/______

Mo. Day Year

---

## CONSCIENTIOUS/RELIGIOUS EXEMPTION MUST BE NOTARIZED. USE IMMUNIZATION WAIVER FORM FOR NOTARIZATION.

I hereby certify by notarization that my conscientious or religious belief is opposed to immunizations.

Student Signature (or parent or legal guardian if under 18 years of age)

**MEDICAL EXEMPTION**

Must also complete and include immunization waiver form from our website if unable to meet required immunizations due to medical contraindications. The physical condition of the above-named person is such that immunization would endanger life or health, or is medically contraindicated due to other medical conditions.

Signature of Medical Professional

Date

**USE IMMUNIZATION WAIVER FORM FOR NOTARIZATION FROM OUR WEBSITE.**
Physical Examination by Health Care Provider
MUST BE COMPLETED WITHIN 12 MONTHS PRIOR TO COLLEGE ENTRANCE

Student Name         Birthdate         Today’s date
____________________________________________________________________________________________________________________________
 Height         Weight   Temp.   Pulse   Resp.  BP
____________________________________________________________________________________________________________________________
I find no medical reason to disqualify _____________________________________________ from participation in athletics.

Student’s Name
If disqualified, please explain: ______________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________
Recommendations for treatment, restriction of academic load or physical activity. Please include period of time for restriction and comments on history.
____________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________
Are you this student’s usual provider?  Yes _______  No _______
____________________________________________________________________________________________________________________________
Health Care Provider’s Signature      Date
____________________________________________________________________________________________________________________________
Health Care Provider’s Name (Printed)
____________________________________________________________________________________________________________________________
Street Address      City    State  ZIP
____________________________________________________________________________________________________________________________
Phone number      FAX number
____________________________________________________________________________________________________________________________

EXAMINATION
Normal  Abnormal  Abnormal Findings (numbered and noted)
(no mark = not examined)

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

STUDENT ATHLETES ONLY

OPTIONAL

Sickle Cell Trait status

Vision Screening

Hgb/Hct

Cholesterol

Urinalysis

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

Student’s Name
If disqualified, please explain: ____________________________________________________________
____________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________

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