Grand View University
Student Life Office
1200 Grandview Avenue • Des Moines, Iowa 50316
515-263-2800 • fax: 515-263-6192

Student Health History

Fill out completely and RETURN TO THE STUDENT LIFE OFFICE prior to participation.

To be completed by ALL STUDENTS.

Name _____ Student ID _____
Last First MI

Date of Birth _____ Sport (if athlete) _____ Gender Identity ❑ Male ❑ Female

Home Address _____
Street

_____
City State Zip

Student Cell Number _____ Year in School ❑ Freshman ❑ Sophomore ❑ Junior ❑ Senior

Emergency Contact _____ Emergency Contact Phone _____

Health Care Provider _____

Medical History

Have you ever had any of the following? Respond to every item and elaborate below on all items marked yes.

ALL STUDENTS	Yes	No
Hospitalized	❑	❑
Surgery	❑	❑
High blood pressure	❑	❑
Heart murmur	❑	❑
Racing heart/skipped heartbeats	❑	❑
Seizure, 'fit' or epilepsy	❑	❑
Eye or vision problems	❑	❑
Other medical problems (infectious mononucleosis, diabetes, anemia, etc.)	❑	❑

	Yes	No
Presenty under doctor's care	❑	❑
Current medication or pills	❑	❑
Allergies (medicine, bees, etc.)	❑	❑
Skin problems (itching, rash, acne)	❑	❑
Trouble breathing or cough during or after exercise	❑	❑
Glasses or contacts	❑	❑

ATHLETES ONLY	Yes	No
Dizzy during or after exercise	❑	❑
Chest pain during or after exercise	❑	❑
Head injury	❑	❑
Knocked out or unconcsious	❑	❑
Stinger, burner or pinched nerve	❑	❑
Heat cramps, heat illness or muscle cramps	❑	❑
Sprained, strained, dislocated, fractured, broken or repeated swelling or other injuries of bones or joints	❑	❑

	Yes	No
Medical problem or injury since last evaluation	❑	❑
Missing an eye, kidney or testicle	❑	❑
Use special equipment (pads, braces, eye guard, etc.)	❑	❑
Anyone in your family…		
Died of heart problems or sudden death before age 50	❑	❑
Had Marfan's Syndrome	❑	❑

When was your last tetanus shot? _____

Females only First menstrual period? _____

Last menstrual period? _____ Longest time between your periods last year? _____

Please explain any **YES** answers: _____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Student Signature _____ Date _____

Immunizations

Attach a copy of your most up-to-date immunization record.

Required and Recommended Vaccinations:

Measles/Mumps/Rubella (MMR) – first vaccine must be after age one; second vaccine must be at least 28 days after first vaccine
Meningitis (Menactra) – one dose age 16 or older

International Students ONLY: TB (Tuerculosis) Screening

❑ Vaccination record received. MMR dates: _____ Meningitis (Menactra) date(s): _____

❑ Vaccination record not provided to Grand View University as requested.

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Physical Form – Athletes and Nursing Students ONLY

Fill out completely and RETURN TO THE STUDENT LIFE OFFICE prior to participation. Must be completed annually.

Name _____
Last First MI

Are you: ❑ Athlete ❑ Nursing student ❑ Both

To be completed by a health care provider.

Height _____ Weight _____ Blood Pressure _____ Pulse _____ Resp _____ T _____ °F

Uncorrected Vision: Right eye _____ Left eye _____ Corrected Vision: Right eye _____ Left eye _____

Physical Examination

1. Eyes ❑ Ok _____
2. Ears ❑ Ok _____
3. Nose ❑ Ok _____
4. Throat ❑ Ok _____
5. Neck ❑ Ok _____
6. Skin ❑ Ok _____
7. Heart ❑ Ok _____
8. Lungs ❑ Ok _____
9. Abdomen ❑ Ok _____
10. Extremities ❑ Ok _____
11. Spine ❑ Ok _____
12. Breast ❑ Ok _____
13. Hernia ❑ Ok _____
14. Thyroid ❑ Ok _____

Nursing Students: must be constantly able to meet the following demands.

MENTAL/COGNITIVE DEMANDS:

1. The environment may cause high stress levels due to constant interruptions, high volume urgency of issues, and interactions with a wide variety of professionals and personalities.
2. Must be able to work independently and assume responsibility for timely completion of assigned functions.
3. Must be able to follow verbal and written instructions.
4. Ability to learn basic computer skills.

PHYSICAL REQUIREMENTS:

Physical Demands (strength)

1. Department of Labor level III tasks: MEDIUM – Exert up to 50 lbs. of force occasionally, and/or up to 25 lbs. of force frequently, and/or up to 10 lbs. of force constantly. Typically on feet standing or walking a minimum of 6 hours out of an 8 hour day.

Physical Demands (movement)

2. Able to lift, push, pull or carry, in order to move patients and/or items from one position or place to another (either mechanically or with a co-worker).
3. Able to stoop, kneel, crouch, crawl, in order to maneuver around within or about the environment to provide care needed.
4. Able to reach, handle, finger and feel in order to manipulate wide variety of equipment, and some complex equipment, and distinguish characteristics of objects, such as sign, shape, temperature or texture.

Physical Demands (auditory)

5. Able to express or exchange ideas by means of the spoken word in order to convey oral information to patients, physicians, families, visitors and public as well as giving instructions to other works accurately, loudly, or quickly.
6. Able to hear in order to identify various kinds and character of sounds, including the ability to receive detailed information through oral communications, and to make fine discriminations in sounds, such as when listening to lungs and heart sounds.

Physical Demands (taste/smell)

7. Able to smell and distinguish with a degree of accuracy, differences or similarities in intensity or quality of odors, or recognizing particular odors, such as odors indicating infection or other medical completions or emergencies, such as a patient's call for help.

Physical Demands (vision)

8. Possess visual acuity and clarity at close range to focus and read small print such as identification bands, thermometers.
9. Possess visual acuity and depth perception for distance vision related to moving people and things within and through the environment, and ability to judge distance and spatial relationships.
10. Possess color vision in order to identify and distinguish colors, such as on-site test results.

Nursing students will have additional clinical requirements once admitted to the major.

Status

❑ Cleared for full activity ❑ Cleared, with restrictions ❑ Not cleared for activity

Comments, restrictions, other medical concerns: (i.e., asthma, diabetes, meds, allergies, etc.) _____

_____

_____

_____

Health Care Provider's Name (print) _____

Health Care Provider's Signature _____ Date _____