



# DAKOTA WESLEYAN UNIVERSITY

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# Student Physical Form

Year \_\_\_\_\_ Enrolling as:  Freshman  Sophomore  Junior  Senior  Transfer  
Major(s) \_\_\_\_\_ Sport(s) \_\_\_\_\_

## I. PERSONAL INFORMATION

Name \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Last \_\_\_\_\_ MI \_\_\_\_\_ First \_\_\_\_\_ Age \_\_\_\_\_ Sex:  Male  Female Marital Status:  Married  Single  Divorced  
Home Address \_\_\_\_\_ Street or P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone No. \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Name \_\_\_\_\_ Address \_\_\_\_\_ Phone No. \_\_\_\_\_ Relationship \_\_\_\_\_  
Family Doctor \_\_\_\_\_ Student Cell Phone No. ( \_\_\_\_\_ ) \_\_\_\_\_

## II. MEDICAL HISTORY

 Check Yes or No for each condition. If yes, explain condition, verifying if present or past.

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
		Asthma			Sexually Trans. Disease			Convulsions
		Cancer			Fainting Spells			Tendency to Bleed
		Chickenpox			Frequent Headaches			Thyroid Trouble
		Chronic Cough			Cong. Birth Defect			Tuberculosis
		Hepatitis B			Shoulder Injury			Diabetes
		Head Injury			Wrist/Hand Injury			Neck/Back Injury
		Elbow Injury			Chemical Dependency			Hip/Groin Injury
		Ankle/Foot Injury			Heat Illness/Cramps			Abdominal Injury
		Surgery			Knee			Hernia

Explanations \_\_\_\_\_

Mental illness and/or depression?  Yes  No If yes, list diagnosis \_\_\_\_\_

Other disorder(s) you have that are not listed above \_\_\_\_\_

Are you currently on any medications?  Yes  No If yes, list \_\_\_\_\_

Do you have any allergies?  Yes  No If yes, list \_\_\_\_\_ Latex allergy?  Yes  No

Does your family have a history of sudden death, cardiorespiratory disease or high blood pressure?  Yes  No

If yes, list \_\_\_\_\_

Are you an individual with a documented physical, psychological or learning disability?  Yes  No

If yes, list specifically \_\_\_\_\_

Alcohol consumption?  Yes  No # of drinks/month \_\_\_\_\_. If yes, have you been through a rehab program?  Yes  No

Drug use?  Yes  No Type \_\_\_\_\_. If yes, have you been through a rehab program?  Yes  No

## III. PHYSICAL EXAMINATION

 Completed by a physician or mid-level provider Date of Exam \_\_\_\_\_

Have you reviewed the student's medical history with the student?  Yes  No

Date of current Tuberculin Skin Test (within the past 12 months) \_\_\_\_\_ Result \_\_\_\_\_

(if positive TB skin test in the past, submit copy of current chest X-ray)

Blood Pressure \_\_\_\_\_ Pulse Rate and Quality \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

Vision without/with glasses \_\_\_\_\_ Right \_\_\_\_\_ Left \_\_\_\_\_

Normal	Abnorm		Normal	Abnorm		Normal	Abnorm	
		Head, Scalp, Face			Wrist			Genitourinary
		Ears			Hand			Hip/Groin
		Eyes			Adenopathy			Hernia
		Nose			Cardiovascular			Skin
		Mouth/Throat			Lungs/Respiratory			Knee
		Teeth			Metabolic/Endocrine			Ankle
		Neck			Abdomen			Feet
		Shoulder			Trunk			Emotional/Psychological
		Elbow			Gastrointestinal			

Explanation of abnormalities or comments \_\_\_\_\_

## PROVIDER RECOMMENDATION

 Check appropriate box

Approved without limitations  Approved with the following limitations \_\_\_\_\_

Not approved for participation \_\_\_\_\_

Provider's Name \_\_\_\_\_

Signature \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

I have truthfully answered all of the questions listed above and understand that withholding any history of prior injury or illness may release Dakota Wesleyan University from any financial responsibility or legal liability for pre-existing conditions.

I understand the information on this medical history/exam form is an entrance requirement for DWU. This information will be treated confidentially within the offices of DWU that may require this information. Offices include but may not be limited to Enrollment Services, Campus Life/Health Services, Nursing, Student Services and Athletic Departments. I hereby authorize DWU to use information to meet the university requirements.

### Mandatory Attachments

- Copy of your insurance card (front and back)
- Proof of two MMR vaccines
- Proof of Hepatitis B vaccine – recommended for all students, **mandatory for nursing and athletic training majors**

Student's Full Signature \_\_\_\_\_

Date \_\_\_\_\_

White: Campus Life/Health Services Yellow: Athletics