***PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE Completing THE FORMS***

PARENTS/STUDENTS: The Health Form (pgs 2 - 7) must be completed, returned, and verified by the University Wellness Center personnel by May 31st. **SatisFactive completion of this process is required before you can move into your residence hall and register for classes. Varsity Athletes please pay close attention to instructions for physical exam.**

FAX FORMS TO: 931-598-1746 (Preferred Secure Method)  
CONTACT INFORMATION: (Phone): 931-598-1270  
(Email): healthservice@sewanee.edu (Please be advised that email is not a secure form of communication)

HEALTH FORM (Pgs 2 - 7)  
All new students, including transfer students, must complete the Health Form and all required immunizations. Legal safeguards make it necessary for each student to have a physical examination, immunization record, and medical history on file with the University Wellness Center. The primary purpose of this medical record is to provide a basic point of reference in case of future illness, to identify any medical condition requiring attention before it interferes with your studies, and to provide the University Wellness Center staff with knowledge of any need for ongoing treatment. All information will be strictly confidential without a signed medical release.

Recommended Vaccines - Due to recent outbreaks of Meningococcal Serogroup B (MenB) on college campuses, the University Wellness Center strongly encourages all students/parents to discuss the need for this vaccine with their primary care physician. A letter from our Medical Director regarding MenB can be found at [http://www.sewanee.edu/media/student-life/support/Meningitis-B-Vaccination-Information.pdf](http://www.sewanee.edu/media/student-life/support/Meningitis-B-Vaccination-Information.pdf). You may also find information on the CDC website at [http://www.cdc.gov/vaccines/hcp/vis/vis-statements/ mening-serogroup.html](http://www.cdc.gov/vaccines/hcp/vis/vis-statements/ mening-serogroup.html). Hepatitis A is strongly recommended for students who plan to travel abroad.

CONSENT TO TREAT (Pg 6):  
All students under the age of 18 must have a legal parent or guardian sign page 6 (Consent for Treatment of Minor).

VARSITY ATHLETIC PARTICIPATION (Baseball, Basketball, Cheerleading, Cross Country, Equestrian, Field Hockey, Football, Golf, Lacrosse, Soccer, Softball, Swimming & Diving, Tennis, Track & Field, Volleyball): **Physicians must be within 6 months of 1st practice.** Any student wishing to compete in a Varsity Sport must complete the Health Form (pgs 2-7) and the Varsity Athletic Supplemental Forms. Please refer to the website [http://sewanee.tigers.com/information/athletictraining/medicalforms/index](http://sewanee.tigers.com/information/athletictraining/medicalforms/index) to download the Varsity Supplemental Forms. All Varsity Athletes are required by NCAA to have a sickle cell test or proof of testing. **All supplemental forms must be submitted along with the Health Form by May 31st.** For questions regarding varsity sports, supplemental forms or sickle cell testing, please contact the athletic training department at 931-598-1293.

CLUB SPORTS (Men's and Women's Rugby, Crew, Ice Hockey, Club Tennis, Squash and Fencing):  
Any student wishing to compete in a Club sport must complete the Health Form (pgs 2-7) and the Club Sport Supplemental Forms. Please refer to the athletic department website at [http://sewanee.tigers.com/information/athletictraining/medicalforms/index](http://sewanee.tigers.com/information/athletictraining/medicalforms/index) to download the Club Sport Supplemental Forms. Students participating in a club sport are **not** required to have proof of sickle cell testing. **All supplemental club forms must be submitted along with the Health Form by May 31st.** For questions regarding club sports or club supplemental forms, please contact the athletic training department at 931-598-1293.

ACCESSIBILITY ACCOMMODATIONS:  
If you are in need of Academic Accommodations, Temporary Condition Accommodations, Physical Disability Accommodations, or Chronic Health Accommodations, please refer to our website at [http://www.sewanee.edu/student-life/university-wellness-center/new-student-sas/](http://www.sewanee.edu/student-life/university-wellness-center/new-student-sas/). **Accessibility Accommodations Form and documentation supporting your request must be submitted to the University Wellness Center Student Accessibility Services Department at 931-598-1261 by May 31st.**

THE UNIVERSITY WELLNESS CENTER IS HIPAA COMPLIANT (Information regarding HIPAA can be found at [www.hhs.gov/ocr/privacy/](http://www.hhs.gov/ocr/privacy/)).
MEDICAL RECORD:

Student's Name: ___________________________  Nickname: ___________________________  Gender: ___________________________

Date of Birth: ___________________________  SSN: ___________________________  Student's Cell Phone Number: ___________________________

Mailing Address: ___________________________  City: ___________________________  State/Zip: ___________________________

Parents', Guardian, Spouse's Name: ___________________________

Home Phone: ___________________________  Mother's Cell Phone: ___________________________  Father's Cell Phone: ___________________________

EMERGENCY CONTACT: ___________________________  Relationship (Mandatory): ___________________________

Home Phone: ___________________________  Cell: ___________________________  Work: ___________________________

INSURANCE

All students are required to have adequate health insurance that will provide coverage while in the Sewanee area. It is the responsibility of the student and/or parent to ensure that there are no restrictions or limitations with your insurance coverage should medical care be necessary.

PLEASE BE ADVISED THAT HMO, MANAGED CARE PLANS, KAISER, AND STATE MEDICAID PLANS MAY NOT PROVIDE COVERAGE IN THE SEWANEE AREA

HEALTH INSURANCE:

<table>
<thead>
<tr>
<th>NAME &amp; ADDRESS OF INSURANCE COMPANY</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Policy Holder</td>
<td>Policy Holders DOB &amp; SSN</td>
</tr>
<tr>
<td></td>
<td>Employer</td>
</tr>
<tr>
<td></td>
<td>HMO</td>
</tr>
<tr>
<td>Policy ID/Certificate Number</td>
<td>Group Number</td>
</tr>
<tr>
<td></td>
<td>(Required Information)</td>
</tr>
</tbody>
</table>

** A CLEAR COPY OF BOTH THE FRONT AND BACK OF THE INSURANCE CARD MUST BE SUBMITTED WITH FORMS **

☐ I have attached a copy of the front and back of my insurance card

PERMISSION FOR DIAGNOSTIC AND TREATMENT PROCEDURES

I hereby authorize the staff of the University Wellness Center, their agents or consultants, to perform diagnostic and treatment procedures, which in their judgment may become necessary while the student is enrolled at the University of the South. I understand that Wellness Center professionals will have access to patient records, as deemed necessary, to facilitate and implement effective treatment.

Student Signature: ___________________________  Date (mm/dd/yr): ___________________________

Parent/Guardian Signature: ___________________________  Date (mm/dd/yr): ___________________________
FAMILY HISTORY

<table>
<thead>
<tr>
<th>AGE</th>
<th>OCCUPATION</th>
<th>STATE OF HEALTH/CHRONIC ILLNESSES</th>
<th>IF DECEASED, AGE AT DEATH</th>
<th>CAUSE OF DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

List immediate family history of any disease, such as diabetes, hypertension, migraines, thyroid disorder, heart disease, cancer, etc., and family member's relationship to you:

HEALTH HISTORY

If you have ever had any of the following conditions or symptoms, please place a check mark in the appropriate box.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Abnormal Pap Smear</th>
<th>Dental Appliance Use</th>
<th>Hemorrhoids</th>
<th>Mononucleosis (Year)</th>
<th>Self-Injurious Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADD/ADHD</td>
<td>Diabetes</td>
<td>Dizziness/Painting Spills</td>
<td>Hernia</td>
<td>MRSA/Skin Infections</td>
<td>Sexually Transmitted Disease</td>
</tr>
<tr>
<td>Anemia/Blood Disorder</td>
<td>Eye Injury or Disease</td>
<td>Irregular Periods/Severe Cramps</td>
<td>Neck Pain/Injury</td>
<td>Neck Pain/Injury</td>
<td>Shortness of Breath</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Drug/Alcohol Problem</td>
<td>Frequent Headaches</td>
<td>Irritable Bowel Syndrome</td>
<td>Orthotic Use/Wear</td>
<td>Smoking/Tobacco Abuse</td>
</tr>
<tr>
<td>Asthma/Inhaler Use</td>
<td>Gallbladder/Gallstone Issue</td>
<td>Knee Problems</td>
<td>Pneumonia</td>
<td>Pneumonia</td>
<td>Thyroid Problem</td>
</tr>
<tr>
<td>Back Pain/Problems</td>
<td>Gout</td>
<td>Kidney Infection/Stones</td>
<td>Recurrent Bronchitis</td>
<td>Recurrent Bronchitis</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Bone/Joint Problems</td>
<td>Cancer</td>
<td>Head Injury/Concussion</td>
<td>Learning Disability</td>
<td>Recurrent Sinusitis</td>
<td>Ulcer - Stomach/Duodenal</td>
</tr>
<tr>
<td>Breast Mass/Problems</td>
<td>Cardiac Problems</td>
<td>Hearing Loss</td>
<td>Low Blood Pressure</td>
<td>Reproductive Surgery</td>
<td>Urinary Infection/Problems</td>
</tr>
<tr>
<td>Chemotherapy/Radiation</td>
<td>Chest Pain</td>
<td>Heart Burn/Add Reflux</td>
<td>Malaria (Year)</td>
<td>Rheumatic Fever</td>
<td>Vision Problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Heart Murmur</td>
<td>Migraines</td>
<td>Seizures/Epileptic Attack</td>
<td>Other</td>
</tr>
</tbody>
</table>

Explain conditions checked:

________________________________________________________________________

Are you currently taking any medications including any type of hormonal therapy? _____ Yes _____ No If so, list name and dosage:

________________________________________________________________________

Do you have any drug allergies? _____ Yes _____ No If so, name the drug and what type of reaction you have with the medication:

________________________________________________________________________

Do you have any other allergies? _____ Yes _____ No If so, explain:

________________________________________________________________________

Have you ever been admitted to the hospital? _____ Yes _____ No If so, please give date and reason for admission:

________________________________________________________________________

Do you have any physical challenges or conditions that may impact your activity? _____ Yes _____ No If so, explain:

________________________________________________________________________

MENTAL HEALTH HISTORY

Have you received treatment for psychological/psychiatric problems (e.g., anxiety, depression, ADHD, etc)? _____ Yes _____ No If yes, explain:

________________________________________________________________________

By whom were you treated?

Name, Address and Contact Number for Mental Health Provider

________________________________________________________________________

If medication was/is used for treatment, please list medication, dosage and how often the medication is/was taken:

________________________________________________________________________

Have you ever been treated for an eating disorder? _____ Yes _____ No If so, please explain:

________________________________________________________________________

________________________________________________________________________

If provider of eating disorder was different than mental health provider, please list (Name, Address and Contact Number for Provider):
**HEALTH CARE PROVIDER’S REPORT OF PHYSICAL EXAMINATION – REQUIRED FOR ALL STUDENTS**

To the examining health care provider: Please review the student's medical history (page 3 of this form) and complete the provider's form below, as well as the student's immunization record. **Please comment on all positive answers.** This student has been accepted to the University – the information supplied will not affect his/her status; it will be used in the service of providing health care, if necessary. This information is strictly for use of the University Wellness Center and Athletic Training Staff (only if student is participating in a sport) and will not be released without student consent. **Physicals must be within a year and Physicals completed by a physician who is a family relative will not be accepted.**

**ATTENTION: STUDENTS PARTICIPATING IN A VARSITY SPORT. ALL VARSITY ATHLETES ARE REQUIRED TO HAVE PROOF OF SICKLE CELL TESTING. PHYSICALS ARE REQUIRED TO BE WITHIN 6 MONTHS OF 1ST PRACTICE AND ADDITIONAL MEDICAL INFORMATION IS NECESSARY (SEE VARSITY SUPPLEMENTAL FORMS). FOOTBALL ATHLETES ARE REQUIRED BY THE NCAA TO HAVE A PHYSICAL BY AN MD (NP, PA – IS NOT ACCEPTABLE)**

**Student’s Name:** ___________________________  **Date of Birth:** ___________________________  **Date of Exam:** ___________________________

**HEIGHT:** ___________________________  **WEIGHT:** ___________________________  **BMI:** ___________________________  **B/P:** ___________________________  **PULSE:** ___________________________  **TEMP:** ___________________________  **RESP:** ___________________________

**VISUAL ACUITY:** (Corrected R 20/_____ L 20/_____  (Uncorrected R 20/_____ L 20/_____)  **Glasses / Contacts / Both:** ___________________________

<table>
<thead>
<tr>
<th>WNL</th>
<th>ABN</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

**How long have you known this student?**

**Has this student been treated for any significant disease or medical condition other than minor short term illness?**  **Y / N**  If yes, explain: ____________________________________________

Taking into consideration the student’s health history (see page 3 and supplemental pages 6-7 for varsity athletes) and physical examination, is there any reason to restrict/prohibit/limit - walking, exercising, or **participation in sports?**  **Y / N**  Explain: ____________________________________________

Is this student capable of handling college academics?  **Y / N** - Physically  **Y / N** - Mentally  **Y / N** - Developmentally  **Y / N** - Socially  If no, explain: ____________________________________________

Is this student currently under your care and/or taking medication?  **Y / N**  If yes, explain: ____________________________________________

Does this student have any drug and/or food allergies?  **Y / N**  If yes, please list: ____________________________________________

Is the student on a special diet or have dietary restrictions?  **Y / N**  Explain: ____________________________________________

Does this student have a history of an eating disorder, cardiac problems, or attention deficit hyperactivity disorder?  **Y / N**  If yes, please provide a status report/plan of care from the treating physician and/or treating therapist. Providers, complete supplemental form page 10 for students who will be participating in a varsity sport and are taking stimulant medications or medications banned by the NCAA (Comments): ____________________________________________

**Signature of examining health care provider:** ___________________________________________  **Date:** ___________________________

**Phone:** ___________________________  **Fax:** ___________________________

**Address:** ____________________________________________

**City:** ___________________________  **State:** ___________________________  **Zip:** ___________________________

**HEALTH CARE PROVIDER’S REPORT OF IMMUNIZATIONS**

**IMMUNIZATIONS MUST BE COMPLETED AND SUBMITTED ON THIS FORM.** Immunizations not submitted on this form may cause a delay in review and processing. Students who do not have the REQUIRED IMMUNIZATIONS completed and submitted by May 31st will be dropped from enrollment in the fall.

Student’s Name: __________________________ Date of Birth: ___________ Last 4 of SSN: ___________

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### REQUIRED IMMUNIZATIONS and TUBERCULOSIS SCREENING SKIN TEST

#### Tuberculosis (TB) Skin Test – (Must be within the past 6 months) (N/A or Uncompleted is Not Acceptable)

1. Date placed: 
   
   Read: 
   
   Result (in millimeters): ___ mm  Positive  Negative

2. **If PPD is positive,** chest x-ray or Quantiferon testing is required.
   
   X-ray Date: ___________________  Result:  normal  abnormal
   
   Quantiferon Test Date: ___________________  Result:  negative  positive

**IF QUANTIFERON GOLD TEST OR CHEST X-RAY IS POSITIVE, ADDITIONAL TREATMENT PLAN MUST BE ATTACHED/SUBMITTED**

#### Meningococcal (A, C, Y, W-135) – One dose required after the sixteenth birthday.

1. Menactra/Menveo: 

#### MMR (measles, mumps, rubella) – two doses are required.

1. Dose 1 (at age 12 mos. or later): 

2. Dose 2 (at least 28 days after 1st dose): 

#### Tetanus, diphtheria, pertussis – tetanus/diphtheria/pertussis (Tdap) is required within the last 10 years. Tetanus/diphtheria (Td) is not sufficient. Tdap booster recommended for ages 11 – 64 unless contraindicated. If Tdap will expire in the next 3 years please boost.

1. Tdap: 

#### Hepatitis B – three doses of Hepatitis B are required.

1. Dose (1) 

2. Dose (2) 

3. Dose (3) 

#### Polio – if all dates of primary series not known, three primary series are required.

1. IPV and/or OPV: 

#### Varicella – history of chicken pox disease, two doses of the vaccine or a positive antibody titer is required to meet the requirements.

1. Date of disease: 

2. Varicella Immunizations: 

3. Varicella Antibody Titer: 

**If students Titer is non-reactive, patient will need to start Varicella Immunization series**

---

### Recommended Immunizations

#### Hepatitis A – two doses of Hepatitis A

1. Dose (1) 

2. Dose (2) 

#### Bexsero or Trumenba (Meningococcal Serogroup B) – Circle One

Dose (1) 

#### (HPV) Gardasil – (Quadrivalent or Gardasil 9) – Circle One

1. Dose (1) 

2. Dose (2) 

3. Dose (3) 

---

Recommended Immunizations

---

Signature of health care provider: __________________________

Phone: (________)  Fax: (________)  Address: __________________________

City: __________________________ State: __________________________ Zip: __________________________
CONSENT TO TREATMENT OF MINOR

To be completed by parent or legal guardian of student under the age of 18.

Student’s Name: ___________________________ Date of Birth: ___________ Last 4 of SSN: ___________

Parent/Legal Guardian Name: ___________________________

I, the undersigned, parent/guardian of ___________________________, a minor, do hereby state that I have legal custody of the aforesaid child who has enrolled in The University of the South. I hereby authorize the licensed healthcare professionals of the University’s Wellness Center to provide medical treatment for my child, and I consent to any examination (including X-ray examination), anesthetic, blood transfusion, medication, medical or surgical treatment, and/or hospital care that is deemed advisable by, and is to be rendered under the general or special supervision of any licensed healthcare professional, whether diagnoses or treatment is rendered at the Wellness Center or at the office of any licensed healthcare provider or a hospital. I agree to assume financial responsibility for all expenses of such care.

It is understood that this authorization is given in advance of any specific diagnosis or treatment, or hospital care being required, and is given to provide specific consent to any and all such diagnoses, treatment, or hospital care that any aforementioned healthcare provider in the exercise of his/her best judgment may deem advisable.

I understand that this authorization will be in effect until my child reaches age 18.

_________________________________________ ___________________________ ___________
Parent/Legal Guardian Signature Relationship to Patient Date
UNIVERSITY WELLNESS CENTER

ATHLETES PARTICIPATING IN A VARSITY/CLUB SPORT

Authorization to Release/Obtain Information

Name: ___________________________ DOB: ___________________________

I authorize University Wellness Center Health Service to RELEASE my health information to:

University of the South
University Athletic Training Department
Director of Athletics
Athletic Training Staff

PURPOSE OF THIS REQUEST: Continuity of Care

TYPE OF RECORDS AUTHORIZED: Medical Health Form (pgs 2 – 7)

Student Signature ___________________________ Date ___________________________

Athletes (Varsity and Club) must sign in order to have your health form shared with the Athletic Department. The athletic department requires all athletes to have a physical and medical history to be on file in the training department.