FINLANDIA UNIVERSITY

Finlandia University Health Form

Name_____ **S.S.#**_____
(First) (Middle Initial) (Last)

Local Address_____
(While attending Finlandia University)

City_____ **State**_____ **ZIP Code**_____

☐ **Male** ☐ **Female** **Date of Birth**_____ **Telephone**_____

Cell Phone_____ **E-mail**_____

GUARDIAN / Mother:

Name_____
(First) (MI) (Last)

Address_____
(Street)

Address_____
(City) (State) (Zip)

Telephone_____
(Home)

_____
(Work)

_____
(Cell)

Father:

Name_____
(First) (MI) (Last)

Address_____
(Street)

Address_____
(City) (State) (Zip)

Telephone_____
(Home)

_____
(Work)

_____
(Cell)

INSURANCE INFORMATION – THIS SECTION MUST BE COMPLETELY FILLED IN.

Insured by: ☐ **MOTHER** ☐ **FATHER** ☐ **SELF** **(Check one)**

Company Name_____

Company Address_____

Company Policy #_____ **Group #**_____ **Phone #**_____

Does your insurance company require you to have a referral? ☐ **Yes** ☐ **No**

Clinic Name_____ **Physician**_____

Address_____ **Phone**_____

_____

Is your insurance a temporary policy? ☐ **Yes** ☐ **No** **If yes, dates?** _____**to**_____

Is your insurance provider an international carrier? ☐ **Yes** ☐ **No**

If yes, does your policy cover intercollegiate athletics within the USA? ☐ **Yes** ☐ **No**

*****PLEASE ENCLOSE A COPY (FRONT AND BACK) OF YOUR INSURANCE CARD*****

PLEASE CONTINUE ON BACK

Health History Form

To be completed by the student and reviewed by examining physician.

Please answer all questions by checking yes or no. Explain any "yes" answers in the space provided at the bottom of this page or on a separate piece of paper.

Disease and Illness

1. Have you ever experienced an epileptic seizure or been informed that you might have epilepsy? ❑ YES ❑ NO
2. Have you had hepatitis during the past three years? ❑ YES ❑ NO
3. Have you been treated for infectious mono-nucleosis, viral pneumonia or other infectious disease during the past 12 months? ❑ YES ❑ NO
4. Have you ever been treated for diabetes? ❑ YES ❑ NO
5. Have you ever been told that you have a heart murmur? ❑ YES ❑ NO
6. Has anyone in your family under the age of 35 died suddenly? ❑ YES ❑ NO
7. Have you had chest discomfort or chest pain during exercise including (or such as) rapid or irregular heartbeat? ❑ YES ❑ NO
8. Have you fainted during exercise? ❑ YES ❑ NO
9. Has anyone in your family been diagnosed with a thickened heart? ❑ YES ❑ NO
10. Does anyone in your family have Marfan's Syndrome (Abe Lincoln's disease)? ❑ YES ❑ NO

Head and Neck Injuries

11. Have you ever been "knocked out" or experienced a concussion during the past three years? If so, give dates (answer below). ❑ YES ❑ NO
12. If answer to Question 11 is Yes, have you been "knocked out" more than once? Give dates (answer below). ❑ YES ❑ NO
13. If answer to Question 11 or 12 is Yes, did the attending physician have you stay overnight in a hospital? If Yes. give dates and details (answer below). ❑ YES ❑ NO
14. Have you ever had a Jammed neck, pinched nerve, whiplash or severe headaches? If so, give dates and details (answer below). ❑ YES ❑ NO
15. Do you wear eye glasses or contacts? ❑ YES ❑ NO
16. If answer to 15 is yes, do you wear them during athletics? ❑ YES ❑ NO
17. Do you wear any dental appliance? If answer is Yes, check the appropriate appliance: ❑ YES ❑ NO

❑ Permanent Bridge ❑ Permanent ❑ Crown ❑ Jacket ❑ Removable ❑ Partial ❑ Full Plate

Bone and Joints

18. Have you ever had a fracture? If so, indicate anatomical site of fracture and date (answer below). ❑ YES ❑ NO
19. Have you ever had a shoulder injury that incapacitated you? ❑ YES ❑ NO
20. Have you ever been advised to have surgery to correct a shoulder condition? ❑ YES ❑ NO
21. If answer to Question 19 is Yes, has the surgery been completed? Give date. ❑ YES ❑ NO
22. Have you ever experienced a severe sprain, dislocation or fracture to either elbow? If so, give date (answer below). ❑ YES ❑ NO
23. Have you ever had an injury to your back that required medical treatment? ❑ YES ❑ NO
24. Do you ever experience pain in the back? If so, indicate frequency with which you experience pain by checking one of the following. ❑ YES ❑ NO

❑ Very Seldom ❑ Occasionally ❑ Frequently ❑ Only After Vigorous Exercise

25. Have you ever experienced a strain of either knee accompanied with severe swelling? ❑ YES ❑ NO
26. Have you ever been told that you injured the ligaments of either knee joint? ❑ YES ❑ NO
27. Have you ever been told that you injured the cartilage of either knee joint? ❑ YES ❑ NO
28. Have you ever been advised to have surgery to correct a knee condition? ❑ YES ❑ NO
29. If answer to Question 28 is Yes, has the surgery been completed? ❑ YES ❑ NO
30. Have you ever experienced a severe sprain of either ankle? ❑ YES ❑ NO
31. Do you have a pin, screw or plate somewhere in your body as a result of bone or joint surgery? ❑ YES ❑ NO
    If yes indicate the anatomical site and give date of surgery (answer below).

General Medical Data

32. Have you ever had any operations? If so, indicate anatomical site of operation and give date (answer below). ❑ YES ❑ NO
33. Have you ever had any additional illnesses or injuries (not mentioned above)? If so, indicate specific illness or operation (answer below). ❑ YES ❑ NO
34. Have you ever been advised by a medical doctor not to participate in sports? For what reason? ❑ YES ❑ NO
35. Are you currently on prescribed medications or drugs? If so, indicate name of drug and why it was prescribed. ❑ YES ❑ NO
36. Do you have any allergies or are you allergic to any general medications? If so, please list them. ❑ YES ❑ NO
    (example; aspirin, sulfa, penicillin, etc.) (answer below)?
37. Are you prone to any conditions in athletics such blisters, shin splints? If so, please indicate which conditions (answer below). ❑ YES ❑ NO
38. Do you have sickle cell anemia or sickle cell trait? ❑ YES ❑ NO
39. Have you had any heat related illnesses (heat cramps, heat exhaustion, heat stroke)? ❑ YES ❑ NO
40. Are you asthmatic? ❑ YES ❑ NO
41. (Women only) Are you currently menstruating regularly? If not, how often do you menstruate? (answer below) ❑ YES ❑ NO

_____

_____

_____

_____

_____

I,_____, do hereby release the Finlandia University & its contracted sports medicine staff from all responsibility for any injury or consequences resulting from any information that I provided or ANY information that I failed to provide.

_____ _____

Signature of Student (If under 18, signature of legal guardian or parent) Date

PHYSICAL EXAMINATION ***(To be completed by examining physician)*** Date: _____

Name: _____ Sex:_____ Age: _____ Date of Birth: _____

Height: _____ Weight: _____ BP:_____ /_____ Pulse: _____

Vision: R 20/_____ L 20/_____ Corrected: ❑ Yes ❑ No Pupils: _____

	Normal	Abnormal Findings	Initials
Cardiopulmonary			
Pulses			
Heart			
Lungs			
Tanner Stage			
Skin			
Abdominal			
Genitalia			
Musculoskeletal			
Neck			
Shoulders			
Elbows			
Wrists			
Hands			
Back			
Knees			
Ankles			
Feet			
Other			

Clearance: ❑ Cleared

❑ Cleared after completing evaluation/rehabilitation for: _____

_____

❑ Not cleared for: ❑ Collision

❑ Contact

❑ Non-Contact ❑ Strenuous ❑ Moderately Strenuous ❑ Non-Strenuous

Due to:

_____

_____

_____

_____

Recommendation: _____

_____

_____

_____

_____

_____

Name of Physician:_____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Signature of Physician: _____