Butler University Health Services
530 W 49th Street Indianapolis, IN 46208
317-940-9385 317-940-6403 (FAX)

PLEASE MAIL DIRECTLY TO HEALTH SERVICES
Due Date August 1st or Jan 1st upon admission

INSTRUCTIONS:

1. A completed and up-to-date health form is **required** by Butler University.
2. **If this form is not completed and/or absent from Health Services, a hold will be placed on the student's registration for the following semester**.
3. The required physical is to be performed and signed by a M.D., A.N.P., PA-C, or D.O. and is to be completed within the last 12 months.
4. All information must be in English.

Medical History Form
(Type or print in ink)

This information is strictly confidential for the use of the Health Services and will not be released to anyone without your knowledge and written consent or as required by law.

Last Name	First Name	MI	School ID #	
Date of Birth	Age	Sex/Gender	Country of Birth	
Permanent Address	City	State	Zip Code	( ) Telephone #
Local Address	City	State	Zip Code	( ) Cell #

In Case of Emergency, Notify:			
Name	Relationship	( ) Telephone Number	( ) Work Number
Address	City	State	Zip Code

Health Insurance Information

Butler University requires that students possess health insurance while enrolled. You will be contacted annually via e-mail and asked 1) to provide evidence of health insurance (waive) or, 2) to voluntarily enroll in the BU-sponsored plan. Those who do not waive are automatically enrolled in and charged for the BU-sponsored plan.

More info: http://www.butler.edu/health-services/student-health-insurance/

(*Please bring a copy of your insurance card when you seek care at Health Services*)

HAVE YOU HAD?	YES	NO		YES	NO
Head Injury with Unconsciousness			Sexually Transmitted Disease		
Asthma			Malaria		
Recurrent Headaches			Chicken Pox		
Seizure Disorders			Scarlet Fever		
Hearing Loss			Hay Fever		
Recurrent Ear Infections			Rheumatic Fever		
Visual Problem (other than glasses)			High Cholesterol		
Thyroid Problem			Hepatitis A,B, or C		
Heart Problem/Murmur			Diabetes		
Kidney/Urinary Tract Problem(s)			High Blood Pressure		
Gynecology Problem(s)			Digestive Tract Problem		
Recent Weight Change			Cancer/Tumor/Cyst		
Bleeding/Blood Disorder			Spinal Cord Disruption		
Tuberculosis			Eating Disorder		
Mononucleosis			Fainting		
Females: Menstrual Problems Breast Problems			Tobacco Use Pks/Day _____		
Alcohol Use # times per week _____ amount per session _____			Exercise: # times per week ______		

Surgeries / Month – Year:
List Health and/or Health Related Issues:
Alternative Medicine Practices:
Medication Allergies: (**PLEASE LIST NAMES OF ALL MEDICATION ALLERGIES**)
Other Allergies: (**PLEASE LIST ALL OTHER ALLERGIES**)
Routine Medications Taken: (write **NONE** if none)
Significant Family Medical History:

Student's Name ____________________________DOB________ ID ______________________

Immunizations

Include a copy of immunization record with health record

All information must be in English

MANDATORY for All Students

Hepatitis B

Requires three (3) vaccinations
#1 Date: ___________
#2 Date: ___________
#3 Date: ___________

Menactra MCV4

Meningococcal (Groups A, C, Y, and W-135) Polysaccharide Diphtheria Toxoid Conjugate Vaccine

Date Received: ___________

MMR

____ Born before 1957

Requires two (2) vaccinations
#1 Date__________
#2 Date__________

Tetanus-Diphtheria or Tdap

Td in the last **10 years**
Date: ___________

Tdap
Date: ___________

Varicella (Chickenpox)

____ had chickenpox disease

If you have not had Varicella disease, you will need:
One (1) vaccination under age 13, two (2) if over age 13
Dates: _________ and _________

MANDATORY for International Students

Tuberculosis (within last 12 months)

Mantoux Skin Test (read by a health professional)
Date applied __________
Date read __________
Size in mm __________

If you have had a positive PPD test, a chest X-ray is required within the last 12 months. Attach a copy of the X-ray report to the health form.

MANDATORY for All College of Pharmacy and Health Sciences Students

Tuberculosis (within last 12 months)

Mantoux Skin Test (read by a health professional)
Date applied __________
Date read __________
Size in mm __________

If you have had a positive PPD test, a chest X-ray is required within the last 12 months. Attach a copy of the X-ray report to the health form.

RECOMMENDED

Hepatitis A
Requires two (2) vaccinations
#1 Date __________
#2 Date __________

HPV (men & women)
Requires three (3) shots

#1 Date______________
#2 Date______________
#3 Date______________

Physical Examination Record
To be completed by health care provider within the last 12 months.
Must be in English

Full Name of Student: ____

Height: _________ (inches) Weight: _________ (pounds) B/P ____/____ Pulse: ______

Normal	Abnormal		Normal	Abnormal	
___	___	1. HEENT	___	___	6. Genitourinary
___	___	2. Neck	___	___	7. Musculoskeletal
___	___	3. Lungs	___	___	8. Neurological
___	___	4. Heart	___	___	9. Skin
___	___	5. Abdomen			

Describe any abnormalities **OR OTHER HEALTH ISSUES**:
____
____

Other Pertinent Information:
____
____

Signature of MD, PA-C, NP, DO: ____ Date: ______________

Please print or stamp MD, PA-C, NP, DO name: ____________________________ Phone: _____________

Address: ____ Fax: ______________________

HEALTHCARE FOR MINORS – REQUEST AND AUTHORIZATION

Please complete the following for student who will be under 18 years of age at the beginning of the school semester.

PARENTS OF STUDENTS UNDER 18: Pursuant to Indiana Code paragraph 16-36-1-6, I request and authorize the Butler University Health Services medical personnel to provide all reasonably necessary medical care, including but not limited to medical transport, lab tests and possible prescriptions or over-the-counter medications advisable for the health of my child. I acknowledge that no representation or guarantees as to the results or cures will be made.

Signature of Parent/Guardian Date

Students age 18 and older please read and sign:

APPROVAL AND CONSENT FOR TREATMENT

I have reviewed all information on this Health Form and believe it to be accurate. I, the undersigned, authorize and consent to treatment; I understand that I may withdraw my consent at any time. Should I be under eighteen years of age, my parent's (or guardian's) signature above indicates approval and consent for medical treatment at Health Services.

Signature of Student Date

MAINTAIN A COPY OF THIS HEALTH RECORD FOR YOUR FILES

Revised 12/5/11