

Health Form

Return completed form to: Director, Office of Health Services
St. Ambrose University, 518 West Locust Street, Davenport, IA 52803
If you have questions, contact 563/333-6423 or HinesNancyA@sau.edu.

Name _____ Date of Birth _____ SAU ID# _____
Last First Middle Month Day Year

Required Information Checklist

Health Form should be completed and returned to the Office of Health Services by Aug. 1 for fall semester and Jan. 1 for spring semester. This information is confidential and accessible only to authorized health service personnel unless authorization is given for its release.

Proof of current health insurance coverage or proof of elective enrollment in a policy of your choice must be received by the proof of health insurance deadline. Any student who has not responded will be enrolled in a Student Assurance Services insurance policy for the academic term and these charges may not be reversed. International students will be automatically enrolled in the Student Assurance Services insurance policy program, and therefore do not have to complete the online documentation form.

Requirements for ALL STUDENTS

- Personal history (page 2)
- Immunization record, including MMR (measles, mumps, rubella), tetanus and meningitis (page 3)
- Proof of current health insurance documented through online form accessible at www.sau.edu/healthservices.*

Additional Requirements for STUDENT ATHLETES Annual updates required

- Physical examination (page 4)
- Authorization to release information to trainers and coaches (page 6)

Additional Requirements for HEALTH SCIENCES STUDENTS, may also be required for students in programs with clinical or practicum experiences (if you are unsure whether this applies to you, check with your program advisor). Annual updates may be needed depending on individual clinical/practicum site requirements.

- Physical examination prior to admission to the Nursing program
- Physical examination no earlier than three months prior to starting the OT/PT/SLP programs
- Additional immunizations: hepatitis B and varicella (chicken pox) (page 3)
- Tuberculosis (TB) two-step test (page 3)
- Authorization to release information to clinical or practicum sites (page 6)

Additional Requirements for INTERNATIONAL STUDENTS

- Tuberculosis (TB) two-step test done in the U.S. (page 3); the Office of Health Services can arrange testing
- * International students will be automatically enrolled in an insurance policy program, and therefore do not have to complete the online documentation form.

Name _____ Date of Birth _____ SAU ID# _____
Last First Middle Month Day Year

Student Information

To be completed by ALL STUDENTS • Type or print legibly in ink

Gender male female Academic status part-time full-time undergraduate graduate

Resident student (lives on campus) Commuter student (lives off campus)

Local address while at St. Ambrose _____
Address City State Zip Code

Campus phone _____ Cell phone _____

Home information when not at St. Ambrose (if different from above) _____
Address

_____ Home phone _____
City State Zip/Postal Code Country

Name of next of kin to be notified in emergency _____ Relationship _____

Address _____ Phones: home _____ business _____ cell _____

Will you be participating in athletics? yes no sport(s) _____ varsity junior varsity

If yes, see page 4 for annual physical examination requirement.

Program (if applicable) Nursing Occupational Therapy Physical Therapy Speech-Language Pathology

Additional requirements may also apply to these programs Education Kinesiology Social Work

Personal History To be completed by student.

Family History

Comment on all positive answers in space below or on additional sheet.

| HAVE YOU HAD | Yes | No | | Yes | No | | Yes | No |
|----------------------------|-----|----|----------------------------------|---------------|----|----------------------------------|-----|----|
| Scarlet fever | | | Head injury with unconsciousness | | | Diabetes | | |
| Measles | | | | Pneumonia | | | | |
| German measles | | | Hay fever | | | FEMALES ONLY | | |
| Mumps | | | Asthma | | | Irregular periods | | |
| Chicken pox | | | Tuberculosis | | | SURGERY | | |
| Polio | | | High or low blood pressure | | | Appendectomy | | |
| Malaria | | | | Tonsillectomy | | | | |
| Typhoid | | | Rheumatic fever or heart murmur | | | Hernia repair | | |
| Diphtheria | | | | Other | | | | |
| Gum, tooth problems | | | Disease or injury of joints | | | Allergy to any of the following? | | |
| Sinusitis | | | | Back problems | | | | |
| Visual disturbance | | | Tumor, cancer, cyst | | | Penicillin | | |
| Ear, nose, throat problems | | | Stomach or intestinal disorder | | | Sulfonamides | | |
| | | | | | | Serum | | |
| Seizure disorder | | | Mononucleosis | | | Food (which) | | |
| Insomnia | | | Gallbladder disease, gallstones | | | Environmental | | |
| Migraine headache | | | | | | Other | | |
| Hearing loss | | | Hernia | | | | | |
| Thyroid disease | | | Recent weight gain, loss | | | | | |

| | Given name | Age | State of health | Age at death | Cause of death | Marital status |
|----------------------------|------------|-----|-----------------|--------------|----------------|----------------|
| Father | | | | | | |
| Mother | | | | | | |
| Siblings (list separately) | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Have parents, grandparents or siblings ever had any of the following? Yes No Relationship

| | | | |
|---------------------|--|--|--|
| Sickle cell trait | | | |
| Tuberculosis | | | |
| Diabetes | | | |
| Kidney disease | | | |
| Cancer | | | |
| Arthritis | | | |
| Heart disease | | | |
| Asthma, hay fever | | | |
| Seizure disorder | | | |
| High blood pressure | | | |

Remarks or additional information. List all medications you take at this time, and their purpose.

Immunization Record

To be completed and signed by your health care provider

Immunizations 1–3 are required for ALL STUDENTS

1 MMR (Measles, Mumps, Rubella) #1 / / #2 / /
M D Y M D Y

2 Tetanus-Diphtheria-Pertussis

a. Primary series #1 / / #2 / / #3 / / #4 / /
M D Y M D Y M D Y M D Y

b. Booster. Type _____ #1 / / #2 / / #3 / / #4 / /
M D Y M D Y M D Y M D Y

3 Meningococcal Tetravalent (Meningitis) Vaccine is required OR complete Declination of Meningitis Immunization (page 5)

a. Type _____ #1 / / #2 / /
M D Y M D Y

Immunizations 4–6 are recommended, but not required, for ALL STUDENTS

4 Hepatitis A #1 / / #2 / /
M D Y M D Y

a. Combined Hepatitis A and B #1 / / #2 / / #3 / /
M D Y M D Y M D Y

5 Polio, Primary series

a. Three dose series Type _____ #1 / / #2 / / #3 / /
M D Y M D Y M D Y

OR

b. Four dose series Type _____ #1 / / #2 / / #3 / / #4 / /
M D Y M D Y M D Y M D Y

6 Quadrivalent Human Papillomavirus Vaccine (HPV), females only #1 / / #2 / / #3 / /
M D Y M D Y M D Y

Additional Immunizations and Test Records

Additional immunizations and tuberculosis (TB) Test 7–9 (below) are required for ALL HEALTH SCIENCES STUDENTS

Tuberculosis (TB) Test 9 (below) is required for ALL INTERNATIONAL STUDENTS

7 Hepatitis B

a. Type _____ #1 / / #2 / / #3 / /
M D Y M D Y M D Y

AND/OR

b. Hepatitis surface antibody (Titer) reactive non-reactive #1 / / #2 / /
M D Y M D Y

OR

c. Complete Declination of Hepatitis Immunization (page 5)

8 Varicella (Chicken Pox)

a. History of disease yes no or Birth in U.S. before 1980 yes no

b. Immunization #1 / / #2 / /
M D Y M D Y

c. Varicella antibody (Titer) reactive non-reactive #1 / / #2 / /
M D Y M D Y

9 Tuberculosis (TB) two-step test (two administrations given 1–3 weeks apart)

a. First TB skin test result _____ mm of induration reactive non-reactive ... Date given / / Date read / /
M D Y M D Y

Second TB skin test result _____ mm of induration reactive non-reactive ... Date given / / Date read / /
M D Y M D Y

b. Chest x-ray required if any skin test is positive or student has received BCG vaccine. ... reactive non-reactive Date of x-ray / /
M D Y

10 Other vaccines given Type _____ date given / /
M D Y

Type _____ date given / /
M D Y

Health Care Provider Certifying Immunization History

To be completed and signed by your health care provider

Print physician's name _____ Phone (_____) _____

Physician's signature _____ Date _____

Address _____
Address City State Zip

Name _____ Date of Birth _____ SAU ID# _____
Last First Middle Month Day Year

Physical Examination

Age _____ Gender _____ Height _____ Weight _____ Blood pressure _____

Distance vision R: 20/____ Corr. to 20/____ L: 20/____ Corr. to 20/____ Contact lenses yes no Eye glasses yes no

Clinical Evaluation *Are there any abnormalities of the following systems? Describe fully. Use additional sheet if needed.*

| | NORMAL | ABNORMAL |
|---------------------------------|--------|----------|
| Head, ears, nose, throat, teeth | | |
| Respiratory | | |
| Cardiovascular | | |
| Gastrointestinal | | |
| Hernia | | |
| Eyes | | |
| Genitourinary | | |
| Musculoskeletal | | |
| Metabolic/Endocrine | | |
| Neuropsychiatric | | |
| Skin | | |

Drug sensitivity? no yes If so, what? _____

Recommendations for physical activities (physical education, intramurals) unlimited limited no physical education

Explain _____

Do you have any recommendations regarding the care of this student? yes no Explain _____

Is the patient now under treatment for any medical condition? yes no Explain _____

Is there a loss or seriously impaired function of any paired organ? yes no Explain _____

Health Care Provider Certifying Physical Examination

To be completed and signed by your health care provider

Print physician's name _____ Phone (_____) _____

Physician's signature _____ Date _____

Address _____
Address City State Zip

Are you this patient's regular physician? yes no

Name _____
Last First Middle Date of Birth _____ SAU ID# _____
Month Day Year

Declination of Meningitis Immunization

The state of Iowa requires colleges and universities to provide information on meningococcal disease and vaccination to all students who reside in on-campus housing. Only the individual declining immunization, or a legal guardian if student is under age 18, may sign this form. A signature by any other person on behalf of the individual named on this declination form is not permitted under any circumstance.

I have received information about meningitis and the meningitis vaccine, including risks and benefits, as well as the effectiveness and availability of the vaccine from the following health care provider or office _____ .

I have had the opportunity to ask questions about meningitis and the meningitis vaccine, and have had those questions satisfactorily answered.

I voluntarily decline the meningitis vaccine.

Name of student declining (printed) _____

If student is under 18, name of legal guardian declining (printed) _____

Signature of individual declining _____ Date _____
(student, or legal guardian if student is under 18)

Declination of Hepatitis B Immunization

Only the individual declining immunization, or a legal guardian if student is under age 18, may sign this form. A signature by any other person on behalf of the individual named on this declination form is not permitted under any circumstance.

I understand that, as a health sciences student or a student in a program with other practicum experience, I may have exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection or other bloodborne diseases. I voluntarily consent to participation in this educational endeavor, regardless of the risk of exposure and acknowledge that St. Ambrose University is not liable for such exposure risks. I have been encouraged by St. Ambrose University to consult a physician as to his or her recommendation for Hepatitis B vaccination based on my medical history and given the opportunity to be vaccinated with Hepatitis B at my own cost. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have education-related exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series through the physician or clinic of my choice or St. Ambrose University Office of Health Services at the prevailing charge.

I have received information about hepatitis B and the hepatitis B vaccine, including risks and benefits, from the following health care provider or office _____ . I have had the opportunity to ask questions about hepatitis B and the hepatitis B vaccine, and have had those questions satisfactorily answered.

I voluntarily decline the hepatitis B vaccine.

Name of student declining (printed) _____

If student is under 18, name of legal guardian declining (printed) _____

Signature of individual declining _____ Date _____
(student, or legal guardian if student is under 18)

Name _____ Date of Birth _____ SAU ID# _____
Last First Middle Month Day Year

Authorization to Release or Redisclose Information for Student Athletes or Those with Clinical or Practicum Experience

I have had delivered certain health information to St. Ambrose University and authorize St. Ambrose University, 518 Locust Street, Davenport, Iowa, including but not limited to its Office of Health Services personnel, to disclose, redisclose, deliver to and discuss with:

- St. Ambrose Athletic Department, including coaches and trainers
- Faculty clinical coordinators for my academic program and potential clinical sites where I may be considered for assignment
- Or to _____

that health information supplied to St. Ambrose and any information gained from the Office of Student Health Services

OR

the following specific information _____.

NOTE: If information includes mental health treatment, substance abuse treatment or HIV-related information it will not be released unless you sign further authorization agreement below.

This authorization expires on _____, _____; or, if no date is specified, on the termination of my status as a student at St. Ambrose University.

I understand that I may refuse to sign this authorization or revoke this authorization at any time. I understand that my revocation or refusal to sign this authorization will not affect my ability to obtain health care services. I also understand that if I revoke, the revocation will take effect on the day it is received by St. Ambrose University. I understand that if the person or entity that receives the information requested is not covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be redisclosed and will no longer be protected by the regulations. Iowa and/or federal law provides that I have a right to prohibit redisclosure of confidential medical information and further disclosure may not be had without my express written authorization, except as indicated below.

I specifically authorize and consent to the disclosure and redisclosure described above. I understand that the disclosure allows for consultation with Athletic Department or clinical site personnel.

Signature of student or student's legal representative Date Printed name and relationship of student's legal representative

Specific Authorization for Release of Information Protected by State or Federal Law Regarding Mental Health, Substance Abuse Treatment or AIDS-related Information

I acknowledge that information about substance abuse, mental health, and/or AIDS-related conditions is protected by federal and/or state law. I have provided St. Ambrose University with confidential information from the agencies, facilities or individuals indicated below and I SPECIFICALLY AUTHORIZE the release of the following confidential information as indicated (indicate "yes" or "no" for each):

- _____ Substance abuse (drug or alcohol) information from _____
Agency, Facility or Individual
- _____ Mental health information from _____
Agency, Facility or Individual
- _____ AIDS-related information from _____
Agency, Facility or Individual

Signature of student or student's legal representative Date Printed name and relationship of student's legal representative

Federal and/or state law specifically require that any disclosure or redisclosure of substance abuse, alcohol or drug, mental health, or AIDS-related information must be accompanied by the following written statement. This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is *not* sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. See also Chapter 228 and Chapter 141(A) of the Iowa Code and other applicable laws.

Note: Photocopy of this signed authorization shall be as effective as the original