STUDENT HEALTH FORM 2014-2015

Wellness Center Office Use Only
Date Reviewed_____ Reviewed By_____
Comments_____
_____
Contact Dates_____
_____

CONFIDENTIAL HEALTH HISTORY

Name (Last, First, MI) _____Date of Birth (Month/Day/Year)_____

Home Address _____ City,State,Zip, _____Country_____

Home Phone (_____) _____ Cell Phone (_____)_____Sex: M F

Emergency Contact Information

Name _____Relationship _____

Address_____ _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Medical History

Do you have a past or present history of the following? Check all that apply:

___Chicken Pox
___Mumps
___Frequent Infections/Sore Throat
___Asthma
___Hives/Eczema
___Mononucleosis
___Anemia
___Kidney/Bladder Infection
___Bronchitis—Chronic
___Jaundice
___Heart Disease
___Pneumonia
___Kidney Disease/Stone
___Rheumatic Fever
___History of Blood Clots
___Cancer
___Migraine Headaches
___Diabetes
___Hay Fever
___Ulcers
___Bursitis, Chronic Back Pain
___Gout
___Arthritis
___Polio/Meningitis
___High Blood Pressure
___Measles
___Epilepsy
___Sexually Transmitted Infection
___Malaria
___Tuberculosis
___Injuries:
Legs/Feet_____
Head/Neck_____
Back/Chest_____
Pelvis_____

Brief explanation of any marked above _____

_____

Mobility difficulties, hearing loss, sight impairment (circle all that apply). Explain_____

Hospitalizations and/or surgeries_____

Current medications_____

Allergies

If you have an allergy of any kind we recommend that you discuss with your medical provider about the need to carry an epi-pen with you.

Allergies (animals, seasonal, food, etc.) _____

Drug Allergies and reaction_____

If you have any of these concerns:

Substance Abuse	past	current	Eating Disorder	past	current
Depression	past	current	Anxiety/Panic Attacks	past	current
Aspergers	yes		Attention Deficit Disorder	past	current
Recent loss of loved one	yes		Other _____		

Give relevant details to any concern marked above, including any medications taken during the past 4 years_____

_____

_____

IMMUNIZATION RECORD

Students will not be allowed to begin classes without the <u>required</u> immunizations and have the records on file in The Wellness Center.

<u>REQUIRED</u> FOR ALL STUDENTS:

- **Copy of Complete Immunization Records (**attach to form**)**

<u>REQUIRED</u> FOR ALL STUDENTS:

- **MMR (Measles, Mumps, Rubella) <u>Two Doses</u>** **Date - dose #1 _____**

  Date - dose #2_____
- **Tdap Booster** (Tetanus, Diphtheria, Pertussis)

  Date - booster _____

RECOMMENDED FOR ALL STUDENTS:

- **Meningococcal vaccine** (Meningitis)
- **Varicella** (two doses; commonly known as "Chicken Pox"**)**
  No vaccine is needed if there is a good history of natural infection.
- **Hepatitis B series** (three doses**)**

<u>REQUIRED FOR ALL INTERNATIONAL STUDENTS AND STUDENTS WHO ARE AT HIGH RISK OR WHO HAVE TRAVELED ABROAD:</u>

- **Tuberculin Test** (no exemption allowed) **<u>Do not have this test done prior to arrival on campus!</u>** The Tuberculin Test will be completed, on campus, in The Wellness Center.

REQUIRED HEALTH INSURANCE

Westminster College is invested in the health and well-being of our students and therefore requires all students to have adequate insurance coverage. Westminster College works closely with an insurance broker to ensure the best rates and coverage for our students. All students are enrolled in the College-sponsored plan each year.

- **STUDENTS WHO ARE US CITIZENS and have health insurance coverage through parents or elsewhere will not be required to buy the College-sponsored plan, <u>BUT MUST OPT OUT ONLINE EACH YEAR.</u>**

<u>YOU WILL BE BILLED AUTOMATICALLY</u>
<u>FOR THE INSURANCE PREMIUM *unless* YOU OPT OUT!</u>

To opt out, the student needs to complete the online form at http://www.westminster-mo.edu/optout prior to the opt-out deadline, August 31st for fall enrollment and January 31st for spring enrollment.
<u>The opt-out waiver must be completed once each school year.</u>
Parents are encouraged to review insurance issues with their student before arrival on campus and to see that the student is given a copy of the insurance card to carry at all times. Should a student need care beyond the scope of the on-site clinic, such as x-rays, lab work or pharmaceuticals, the student will be responsible for the bill. For this reason, it would be in the student's best interest to have a list of preferred local providers if the coverage extends to the mid-Missouri region.

- **INTERNATIONAL STUDENTS are required to enroll in the College-sponsored health insurance plan (no exceptions).**

PRIVACY STATEMENT

I understand that The Wellness Center at Westminster College may need to use and disclose information about my health or medical problems for the purposes of arranging, conducting, or referring my treatment; for obtaining payment for services; and for operating the practice. I consent to the use of my information for the purposes of treatment, payment and health care operations. I understand that my consent is not needed when the law requires The Wellness Center at Westminster College to report some aspect of my protected health information to a government agency (for example, suspected abuse, communicable disease, and potential for serious bodily harm to myself or others). I understand that I have the right to review The Wellness Center's privacy notice, to request restrictions on the use of my information, and to revoke my consent at a later date.

I understand that if I withhold consent for the use of my information for the purposes of treatment, payment, or operations, The Wellness Center may refuse to undertake my care.

Student's Printed Name _____

Student's Signature_____ **Date**_____

Students under 18:
Parent/Guardian Signature _____ **Date** _____

CONSENT FOR TREATMENT

All Students:

By my signature, I verify that the information provided on this form is true, and I give permission for such diagnosis, tests and therapeutic procedures, as may be deemed necessary for me.

Student's Printed Name _____

Student's Signature_____ **Date**_____

Students under 18:

I grant permission to the medical staff at The Wellness Center, Westminster College, to treat my son/daughter as may be necessary and, if needed, to refer to private care when special service is indicated.

Parent/Guardian Signature _____ **Date** _____

RETURN COMPLETED FORM TO:

Clinic Coordinator/Jackie Pritchett
The Wellness Center 501 Westminster Ave.
Fulton, MO 65251-1299
Phone: 573-592-5361
Fax: 573-592-5180
Email: Jacqueline.Pritchett@westminster-mo.edu