STUDENT HEALTH FORM
2016-2017

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
Autism Spectrum	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

REQUIRED FOR ALL STUDENTS:

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

1. **Copy of Complete Immunization Records (**attach to form**)**

2. **Up-to-date Immunizations: (the following are required)**
   - **MMR (Measles, Mumps, Rubella) Two Doses** **Date - dose 1**_____
     Date - dose 2_____
   - **Tdap Booster (Tetanus, Diphtheria, Pertussis)** **Date -** _____
     Also referred to as Adacel/Boostrix
   - **Meningococcal Vaccine (Meningitis)** **Date – dose 1**_____
     Date – dose 2_____

Also referred to as:
Menactra or Menveo which is the brand name for MCV4 vaccine
Menomune which the brand name for MPSV4 vaccine
Please note: If Menactra, Menveo or Menomune was given to the student BEFORE the age of 16, a second vaccination of either Menatra, Menveo or Menomune will be required.

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 automatically enrolled in the College-sponsored plan each year and must opt out if eligible.

- **STUDENTS WHO ARE US CITIZENS and have health insurance coverage through parents or elsewhere will not be required to buy the College-sponsored plan, BUT MUST OPT OUT ONLINE EACH YEAR.**
- **YOU WILL BE BILLED AUTOMATICALLY FOR THE INSURANCE PREMIUM unless YOU OPT OUT!**

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.

The opt-out waiver must be completed once each school year.

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).**

Tuberculosis (TB) Screening Questionnaire

All incoming students are required to complete the questionnaire

Please answer the following questions:		
Have you ever had close contact with persons known or suspected to have active TB disease?	❑ Yes	❑ No
Were you born in one of the countries listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below)	❑ Yes	❑ No

Afghanistan	Côte d'Ivoire	Kenya	Nicaragua	South Africa
Algeria	Democratic People's Republic of Korea	Kiribati	Niger	South Sudan
Angola	Democratic Republic of the Congo	Kuwait	Nigeria	Sri Lanka
Argentina	Djibouti	Kyrgyzstan	Niue	Sudan
Armenia	Dominican Republic	Lao People's Democratic Republic	Pakistan	Suriname
Azerbaijan	Ecuador	Latvia	Palau	Swaziland
Bahrain	El Salvador	Lesotho	Panama	Tajikistan
Bangladesh	Equatorial Guinea	Liberia	Papua New Guinea	Thailand
Belarus	Eritrea	Libya	Paraguay	Timor-Leste
Belize	Estonia	Lithuania	Peru	Togo
Benin	Ethiopia	Madagascar	Philippines	Trinidad and Tobago
Bhutan	Fiji	Malawi	Poland	Tunisia
Bolivia (Plurinational State of)	Gabon	Malaysia	Portugal	Turkey
Bosnia and Herzegovina	Gambia	Maldives	Qatar	Turkmenistan
Botswana	Georgia	Mali	Republic of Korea	Tuvalu
Brazil	Ghana	Marshall Islands	Republic of Moldova	Uganda
Brunei Darussalam	Guatemala	Mauritania	Romania	Ukraine
Bulgaria	Guinea	Mauritius	Russian Federation	United Republic of Tanzania
Burkina Faso	Guinea-Bissau	Mexico	Rwanda	Uruguay
Burundi	Guyana	Micronesia (Federated States of)	Saint Vincent and the Grenadines	Uzbekistan
Cabo Verde	Haiti	Mongolia	Sao Tome and Principe	Vanuatu
Cambodia	Honduras	Morocco	Senegal	Venezuela (Bolivarian Republic of)
Cameroon	India	Mozambique	Serbia	Viet Nam
Central African Republic	Indonesia	Myanmar	Seychelles	Yemen
Chad	Iran (Islamic Republic of)	Namibia	Sierra Leone	Zambia
China	Iraq	Nauru	Singapore	Zimbabwe
Colombia	Kazakhstan	Nepal	Solomon Islands	
Comoros			Somalia	
Congo				

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2012. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://apps.who.int/ghodata.

Have you had frequent or prolonged visits to one or more of the countries listed above with a high prevalence of TB disease? (If yes, CHECK the countries, above)	❑ Yes	❑ No
Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?	❑ Yes	❑ No
Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease?	❑ Yes	❑ No
Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease – medically underserved, low-income, or abusing drugs or alcohol?	❑ Yes	❑ No

If the answer is YES to any of the above questions, Westminster College requires that you receive TB testing as soon as possible at your own cost. **This does not apply to International Students. As stated above, a tuberculin test will administered on campus.**

If the answer to all of the above questions is NO, no further testing or further action is required.

<u>International Students</u> will be required to have the tuberculin test

- **Do not have this test done prior to arrival on campus!** The Tuberculin Test will be completed, on campus, in The Wellness Center.

Note: Missouri Senate bill No. 197 requires all institutions of higher education in Missouri to implement a targeted testing program on their campuses for all students upon matriculation. Any entering student of an institution of higher education in Missouri that does not comply with the targeted testing program shall not be permitted to maintain enrollment.
Please contact the Wellness Center at 573-592-5361 if you have questions.

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