Health Form

Return this 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.

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.

**REQUIREMENTS FOR ALL STUDENTS** Complete pages 2–4.

- [ ] Personal history (page 2)
- [ ] Immunization record, including MMR (measles, mumps, rubella), tetanus and meningitis (page 3)
- [ ] Tuberculosis (TB) Screening Questionnaire (page 4)

**Additional Requirements for STUDENT ATHLETES** Annual updates required. Complete pages 2–7.

- [ ] Physical examination (page 5)
- [ ] Authorization to release information to trainers and coaches (page 7)
- [ ] Proof of health insurance

**Additional Requirements for HEALTH SCIENCE 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. Complete pages 2–5.

- [ ] Physical examination. Contact your program for specific information (page 5)
- [ ] Additional immunizations: hepatitis B and varicella (chicken pox) (page 3)
- [ ] Tuberculosis test (page 3)
- [ ] Authorization to release information to clinical or practicum sites (page 7)
- [ ] Proof of health insurance

**Additional Requirements for INTERNATIONAL STUDENTS**

- [ ] Proof of health insurance

Return this 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.

**NOTE**

All health records will be shredded seven (7) years after graduation or one (1) year after student inactive status.
Student Information

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

Gender identity ________________________________  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

Cell phone ____________________________

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

Address  
City  
State  
Zip/Postal Code  
Country

Home phone ____________________________

Emergency contact ____________________________  Relationship ____________________________

Address ____________________________  Phones: home ____________________________  business ____________________________  cell ____________________________

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

If yes, see page 5 for annual physical examination requirement.

Personal History To be completed by student.

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

<table>
<thead>
<tr>
<th>HAVE YOU HAD</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Scarlet fever</td>
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<td>Measles</td>
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<td>German measles</td>
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<td>Mumps</td>
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<td>Chicken pox</td>
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<td>Polio</td>
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<td>Gum, tooth problems</td>
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<td>Sinusitis</td>
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<td>Thyroid disease</td>
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Remarks or additional information. List all medications you take at this time, and their purpose.

Familial History

Given name  Age at death  Cause of death  Marital status

<table>
<thead>
<tr>
<th>Father</th>
<th>Mother</th>
<th>Siblings (list separately)</th>
<th>Relationship</th>
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</table>

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<th>No</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
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<td>Mumps</td>
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<td>Chicken pox</td>
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<td>Visual disturbance</td>
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</table>

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

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<thead>
<tr>
<th>Sickle cell trait</th>
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<th>No</th>
<th>Relationship</th>
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<td>Diabetes</td>
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<tr>
<td>Kidney disease</td>
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<td>Cancer</td>
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<td>Arthritis</td>
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<td>Heart disease</td>
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<td>High blood pressure</td>
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</table>
Immunizations 1–3 are required for ALL STUDENTS

1 MMR (Measles, Mumps, Rubella) .......................................................... #1 ___/___/___ #2 ___/___/___ #3 ___/___/___

2 Tetanus-Diphtheria-Pertussis
   a. Primary series .......................................................... #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___
   b. Type of most recent booster  Td ___________ Tdap ___________ .......................................................... ___/___/___

3 Meningococcal Vaccine is required OR complete Declination of Meningitis Immunization (page 6)
   a. MenACWY  Type _____________________________ #1 ___/___/___ booster ___/___/___ #2 ___/___/___ #3 ___/___/___
   b. MenB  Type _____________________________ #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___

4 Polio, Primary series
   a. Three dose series  Type _____________________________ #1 ___/___/___ #2 ___/___/___ #3 ___/___/___
   OR
   b. Four dose series  Type _____________________________ #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___

5 Human Papillomavirus Vaccine (HPV2, HPV4, HPV9)  type _____________________________ #1 ___/___/___ #2 ___/___/___ #3 ___/___/___

6 Hepatitis A .......................................................... #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___
   a. Combined Hepatitis A and B .......................................................... #1 ___/___/___ #2 ___/___/___ #3 ___/___/___

Additional Immunizations and Test Results

Immunizations and Tuberculosis testing [7–9, below] are required for ALL HEALTH SCIENCE STUDENTS
Interferon Gamma Release Assay (IGRA) [9b, below] is required for ALL INTERNATIONAL STUDENTS coming from countries with high incidence of active TB disease (page 4).

7 Hepatitis B
   a. Type _____________________________ AND/OR _____________________________ #1 ___/___/___ #2 ___/___/___ #3 ___/___/___
   b. Hepatitis B surface antibody (Titer) .......................................................... ___/___/___ □ reactive □ non-reactive

8 Varicella (Chicken Pox)
   a. History of disease □ yes □ no or Birth in U.S. before 1980 □ yes □ no
   b. Immunization .......................................................... #1 ___/___/___ #2 ___/___/___ #3 ___/___/___
   c. Varicella antibody (Titer) .......................................................... ___/___/___ □ reactive □ non-reactive

9 Two-Step Tuberculin Skin Test (TST), two administrations given 1–3 weeks apart
   a. First TB skin test result ______ mm of induration □ reactive □ non-reactive . Date given ___/___/___ Date read ___/___/___
   Second TB skin test result ______ mm of induration □ reactive □ non-reactive . Date given ___/___/___ Date read ___/___/___
   b. Interferon Gamma Release Assay (IGRA) method: □ QFT-GIT □ T-Spot □ other . Date given ___/___/___
   result: □ negative □ positive □ indeterminate □ borderline (T-Spot only)
   c. Chest x-ray (required if TST or IGRA is positive). □ normal □ abnormal . Date of x-ray ___/___/___

10 Other vaccines given Type _____________________________ date given ___/___/___
   Type _____________________________ date given ___/___/___

Health Care Provider Certifying Immunization History

Print health care provider’s name _____________________________ Phone (_______)
Health care provider’s signature _____________________________ Date _____________
Address _____________________________ City ______ State ______ Zip ______

To be completed and signed by your health care provider

Page 3 of 7 (continued on next page)
In compliance with guidelines established by the American College Health Association, the TB Screening Questionnaire must be completed by all incoming students.

Name ____________________________________________________________________________________

Date of Birth ___________________ Last  First  Middle Month Day Year

Tuberculosis (TB) Screening Questionnaire
To be completed by ALL STUDENTS • Type or print legibly in ink

1 Have you ever had close contact with persons known or suspected to have active TB disease? ........................................ ☐ yes ☐ no

2 Were you born in one of the countries listed below with a high incidence of active TB disease? ........................................ ☐ yes ☐ no

If yes, CIRCLE the country:

Afghanistan  Colombia  Indonesia  Myanmar  Somalia
Algeria  Comoros  Iraq  Namibia  South Africa
Angola  Congo  Kazakhstan  Nauru  South Sudan
Anguilla  Côte D'Ivoire  Kenya  Nepal  Sri Lanka
Argentina  Democratic People's Republic of Korea  Kiribati  New Caledonia  Sudan
Armenia  Kyrgyzstan  Lao People's Democratic Republic  Nigeria  Syrian Arab Republic
Azerbaijan  Bangladesh  the Congo  Afghanistan  Tajikistan
Belarus  Djibouti  Djibouti  Central African Republic  Chad
Belize  Democratic Republic of Colombia  Comoros  Côte D'Ivoire  Democratic People's Republic of Korea
Benin  Equatorial Guinea  Equatorial Guinea  Eritrea  Djibouti
Bhutan  El Salvador  Equatorial Guinea  Eritrea  Ethiopia
Bolivia  Equatorial Guinea  Equatorial Guinea  Eritrea  Ethiopia
Bosnia and Herzegovina  Cape Verde  Ethiopia  Equatorial Guinea  Eritrea
Botswana  Fiji  Equatorial Guinea  Eritrea  Ethiopia
Brazil  Gabon  Fiji  Equatorial Guinea  Eritrea
Brunei Darussalam  Gambia  Gabon  Ghana  Guinea
Bulgaria  Georgia  Gabon  Ghana  Guinea
Burkina Faso  Ghana  Ghana  Ghana  Guinea
Burundi  Greenland  Ghana  Ghana  Guinea
Cabo Verde  Guam  Greenland  Ghana  Guinea
Cambodia  Guatemala  Greenland  Ghana  Guinea
Cameroon  Guinea  Guinea  Gabon  Ghana
Central African Republic  Guinea  Guinea-Bissau  Ghana  Guinea
Chad  Guyana  Guinea  Guinea  Guinea
China  Haiti  Guinea  Guyana  Haiti
China, Hong Kong SAR  Honduras  Honduras  Guatemala  Guatemala
China, Macao SAR  India  Indonesia  Myanmar  Myanma
Democratic People's Republic of Korea  Kiribati  Korea, Democratic People's Republic of  Korea, Republic of
Democratic Republic of the Congo  Kongo  Congo  Congo  Democratic People's Republic of Korea
Viet Nam  Kongo  Congo  Congo  Democratic People's Republic of Korea
Region of

3 Have you traveled to one or more of the countries listed above? ............................................ ☐ yes ☐ no

If yes, place a check mark by those countries and indicate the length of time spent in the country/countries ____________________________

4 Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, homeless shelters)? ............................................ ☐ yes ☐ no

5 Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? ........ ☐ yes ☐ no

6 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 you must receive TB testing as soon as possible, but at least prior to the start of the subsequent semester and provide documentation to the campus Health Service. The Health Service can provide you with assistance.

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

The above information is true and accurate to the best of my knowledge.

Student signature ____________________________________________________________________________ Date _____________________

page 4 of 7 (continued on next page)
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.

<table>
<thead>
<tr>
<th>NORMAL</th>
<th>ABNORMAL</th>
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<tbody>
<tr>
<td>Head, ears, nose, throat, teeth</td>
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<tr>
<td>Respiratory</td>
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<tr>
<td>Cardiovascular</td>
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<td>Eyes</td>
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<td>Genitourinary</td>
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<td>Neuropsychiatric</td>
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<td>Skin</td>
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</tbody>
</table>

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*

□ I have examined this individual using the criteria above and have included any concerns regarding their safety in working with clients in clinical settings.

Print health care provider’s name_________________________________________ Phone (_______) _______________________

Health care provider’s signature_________________________________________ Date_____________________

Address______________________________________________________________

* Provider must be MD, DO, ARNP or PA
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)

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

I have 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