St Ambrose University
518 W. Locust Street
Davenport, Iowa 52803
www.sau.edu/healthservices

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.

Name _____ Date of Birth _____
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.

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

Name _____ Date of Birth _____
Last First Middle Month Day Year

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

_____ Home phone _____
City State Zip/Postal Code Country

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.

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					

Family History

	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.

Name _____ Date of Birth _____
Last First Middle Month Day Year

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. Type of most recent booster Td_____ Tdap _____ . . . . . ____/___/___
M D Y

3 Meningococcal Vaccine is required OR complete Declination of Meningitis Immunization (page 6)

a. MenACWY Type _____ . . . . . #1 ___/___/___ . . . . . booster ____/__/___
M D Y M D Y

b. MenB Type_____ . . . . . #1 ___/___/___ #2 ____/___/___ #3 ___/___/___
M D Y M D Y M D Y

4 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

5 Human Papillomavirus Vaccine (HPV2, HPV4, HPV9) type _____ #1 ___/___/___ #2 ____/___/___ #3 ____/___/___
M D Y M D Y M D Y

6 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

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 _____ . . . . . #1 ___/___/___ #2 ____/___/___ #3 ___/___/___
M D Y M D Y M D Y

AND/OR

b. Hepatitis B surface antibody (Titer) . . . . . ___/___/___ . . . . . ☐ reactive ☐ non-reactive
M D Y

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
M D Y

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 ____/___/___
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. Interferon Gamma Release Assay (IGRA) method: ☐ QFT-GIT ☐ T-Spot ☐ other_____ Date given ___/___/___
M D Y

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 ____/___/___
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 health care provider's name_____ Phone (_____) _____

Health care provider's signature_____ Date_____

Address_____
Address City State Zip

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

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 _____

Name _____ Date of Birth _____
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**

☐ 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 _____
Address City State Zip

* Provider must be MD, DO, ARNP or PA

Name _____ Date of Birth _____
Last First Middle 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)

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

Name _____ Date of Birth _____
Last First Middle Month Day Year

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