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

NOTE

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

Outbreaks of communicable diseases cause great disruption and emotional and financial burdens for campuses, students, and their families. Please comply with the required and recommended vaccines on page 3 adopted by CDC to prevent or reduce disease clusters and outbreaks on our campus.
Name

Date of Birth

Student ID Number

Student Information

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

Address

Phones: home

business

cell

Will you be participating in athletics?  ☐ yes  ☐ no  sport(s)

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

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

German measles

Mumps

Chicken pox

Polio

Malaria

Typhoid

Diphtheria

Gum, tooth problems

Sinusitis

Visual disturbance

Ear, nose, throat problems

Seizure disorder

Insomnia

Migraine headache

Hearing loss

Thyroid disease

Head injury with unconsciousness

Hay fever

Asthma

Tuberculosis

Rheumatic fever or heart murmur

Disease or injury of joints

Back problems

Tumor, cancer, cyst

Stomach or intestinal disorder

Mononucleosis

Gallbladder disease, gallstones

Herna

Recent weight gain, loss

Diabetes

Pneumonia

FEMALES ONLY

Appendectomy

Tonsillectomy

Hernia repair

Other

Allergy to any of the following?

Given name

Age

State of health

Age at Cause of death

Marital status

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.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Immunizations 1–3 are required for ALL STUDENTS

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

2 Tetanus-Diphtheria-Pertussis
   a. Primary series .......................................................... #1 M D Y #2 M D Y #3 M D Y #4 M D Y
   b. Type of most recent booster  Td_________  Tdap ___________ 

3 Meningococcal Vaccine is required OR complete Declination of Meningitis Immunization (page 6)
   a. MenACWY  Type ____________________________ booster ___________ M D Y
   b. MenB  Type ___________________________ 

4 Polio, Primary series
   a. Three dose series  Type ___________________________ 
   OR
   b. Four dose series  Type ___________________________ 

5 Human Papillomavirus Vaccine (HPV2, HPV4, HPV9)   type ___________

6 Hepatitis A  
   a. Combined Hepatitis A and B ___________________________ 

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
   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 ___________________________ 
   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  positive  negative  Date given ______ M D Y Date read ______ M D Y
   Second TB skin test  result ______ mm of induration  positive  negative  Date given ______ M D Y Date read ______ M D Y
   b. Interferon Gamma Release Assay (IGRA)  method:  QFT-GIT  T-Spot  other 
   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

Print health care provider’s name ____________________________________________ Phone (_______ ) ____________
Health care provider’s signature ____________________________________________ Date ____________________________
Address ___________________________________________________________________
City __________ State __________ Zip ____________

02.21
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

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

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, volunteer, 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) 02.21
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>
</tr>
</thead>
<tbody>
<tr>
<td>Head, ears, nose, throat, teeth</td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
</tr>
<tr>
<td>Hernia</td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
</tr>
<tr>
<td>Genitourinary</td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td>Metabolic/Endocrine</td>
<td></td>
</tr>
<tr>
<td>Neuropsychiatric</td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
</tr>
</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 ___________________________________________________  Address _______________________________

City __________________________ State __________________________  Zip _______________________________

* 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 __________________________________________