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

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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.
**Student Information** To be completed by ALL STUDENTS • Type or print legibly in ink

<table>
<thead>
<tr>
<th>Gender identity</th>
<th>Academic status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ part-time □ full-time □ undergraduate □ graduate</td>
</tr>
</tbody>
</table>

□ Resident student (lives on campus) □ Commuter student (lives off campus)

Local address while at St. Ambrose

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

Cell phone

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

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip/Postal Code</th>
<th>Country</th>
</tr>
</thead>
</table>

Emergency contact

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip/Postal Code</th>
<th>Country</th>
<th>Relationship</th>
</tr>
</thead>
</table>

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**

<table>
<thead>
<tr>
<th>HAVE YOU HAD</th>
<th>Yes No</th>
<th>Yes No</th>
<th>Yes No</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Scarlet fever</td>
<td>Head injury with unconsciousness</td>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td></td>
<td>Pneumonia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>German measles</td>
<td>Hay fever</td>
<td>FEMALES ONLY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td>Asthma</td>
<td>Irregular periods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chicken pox</td>
<td>Tuberculosis</td>
<td>SURGERY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td>High or low blood pressure</td>
<td>Appendectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malaria</td>
<td></td>
<td>Tonsillectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Typhoid</td>
<td>Rheumatic fever or heart murmur</td>
<td>Hernia repair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphtheria</td>
<td></td>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gum, tooth problems</td>
<td>Disease or injury of joints</td>
<td>Allergy to any of the following?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sinusitis</td>
<td>Back problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visual disturbance</td>
<td>Tumor, cancer, cyst</td>
<td>Penicillin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear, nose, throat problems</td>
<td>Stomach or intestinal disorder</td>
<td>Sulfonamides</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizure disorder</td>
<td>Mononucleosis</td>
<td>Food (which)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insomnia</td>
<td>Gallbladder disease, gallstones</td>
<td>Environmental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migraine headache</td>
<td></td>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing loss</td>
<td>Hernia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid disease</td>
<td>Recent weight gain, loss</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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FEMALES ONLY

<table>
<thead>
<tr>
<th>Have parents, grandparents or siblings ever had any of the following?</th>
<th>Yes No</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sickle cell trait</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma, hay fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizure disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High blood pressure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 ___________________ #5 M / D / Y #6 M / D / Y

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

4 Polio, Primary series
   a. Three dose series Type ___________________ #1 M / D / Y #2 M / D / Y #3 M / D / Y
   b. Four dose series Type ___________________ #1 M / D / Y #2 M / D / Y #3 M / D / Y

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

6 Hepatitis A .............................................................. #1 M / D / Y #2 M / D / Y #3 M / D / Y
   a. Combined Hepatitis A and B ............................................... #1 M / D / Y #2 M / D / Y #3 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 ___________________ AND/OR
      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 ___________________ #1 M / D / Y #2 M / D / Y
   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 ___ / ___ / ___ Date read ___ / ___ / ___
      Second TB skin test result ______ mm of induration □ positive □ negative . . . 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) . . . . Date of x-ray ___ / ___ / ___

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

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 ___________________________ 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
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
Dominica
Dominican Republic
Ecuador
El Salvador Equatorial Guinea
Eritrea
eSwatini
Ethiopia
Fiji
French Polynesia Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau

Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Laos People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Mali
Marshall Islands
Mauritania
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Tajikistan
Thailand
Timor-Leste
Togo
Tokelau
Tuvalu
Ukraine
United Republic of Tanzania
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, 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)

05.22
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