



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 W. Locust St., 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

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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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#### 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**

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.

**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						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					

	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

	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 \_\_\_/\_\_\_/\_\_\_  
OR M D Y M D Y M D Y

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 \_\_\_/\_\_\_/\_\_\_  
AND/OR M D Y M D Y M D Y

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 \_\_\_/\_\_\_/\_\_\_  
M D Y 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 \_\_\_/\_\_\_/\_\_\_  
M D Y M D Y

Second TB skin test result \_\_\_\_\_ mm of induration  positive  negative ... Date given \_\_\_/\_\_\_/\_\_\_ Date read \_\_\_/\_\_\_/\_\_\_  
M D Y M D Y

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 \_\_\_/\_\_\_/\_\_\_  
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



Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First Middle Month Day Year

### Physical Examination

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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.*

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	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\**

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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

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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

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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**

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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