

# COTTEY COLLEGE STUDENT HEALTH FORM

All medical information is STRICTLY CONFIDENTIAL, available only to Health Service's personnel, and will not be released in whole or in part without the student's knowledge and consent. Please complete this form and return it in the envelope provided. ***You must meet the immunization requirements and have your complete health record on file in the Health Services Office or your residence hall check-in will be denied.***

ENTERING FALL/SPRING YEAR \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
NAME \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_  
CELL PHONE NUMBER \_\_\_\_\_ HOME PHONE NUMBER \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
street city state zip country

PARENT/GUARDIAN OR OTHER PERSON TO NOTIFY IN CASE OF EMERGENCY  
NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
street city state zip country

DAY PHONE NUMBER \_\_\_\_\_ HOME PHONE NUMBER \_\_\_\_\_  
CELL PHONE NUMBER \_\_\_\_\_

FAMILY PHYSICIAN OR CLINIC NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
street city state zip country

OFFICE PHONE NUMBER \_\_\_\_\_

## MEDICAL INSURANCE

It is highly recommended each student have medical insurance to protect against the potential major costs of accident or severe illness. All international students are required to carry medical insurance.

Please check one:  I AM covered by the hospital/medical insurance program(s) listed below.  
 I AM NOT covered by a hospital/medical insurance program.

SUBSCRIBER \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
GROUP NUMBER \_\_\_\_\_ CERTIFICATE NUMBER \_\_\_\_\_  
COMPANY NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
street city state zip country  
PHONE NUMBER \_\_\_\_\_

Please enclose a photo copy of insurance card, front and back.

NAME \_\_\_\_\_

**MEDICATION INFORMATION**

Please list the medications you take daily.	
Medication	Strength

Are you allergic to any medications?
Medication

**FAMILY HISTORY**

**HAS ANY BLOOD RELATIVE (PARENT, SIBLING, OR GRANDPARENT) EVER HAD THE FOLLOWING?**

Mark All That Apply	Yes	No	Relative
Tuberculosis			
Diabetes			
Cancer			
Kidney Problems			
Asthma			
Heart Attack or Stroke			
Epilepsy or Seizures			
Mental or Emotional Illness			

**PAST OR CURRENT ILLNESS OR CONDITIONS: HAVE YOU EVER HAD OR DO YOU HAVE NOW?**

Mark All That Apply	Yes	No	Detail
Active tuberculosis			
Arthritis			
Asthma			
Attempted suicide			
Bone or joint problems			
Cancer			
Depression			
Diabetes			
Do you smoke?			
Eating disorder			
Epilepsy/seizures			
Eye problems			
Frequent ear infections			
Frequent indigestion			
Frequent sore throats			
Gall bladder problems			
Head trauma/concussion			
Heart murmur/palpitations			
Hemorrhoids			
High blood pressure			
Hives, rashes			
Immune system disorder			
Insomnia			
Jaundice, hepatitis			
Kidney stones			
Menstrual irregularities			
Mental illness			
Pneumonia/bronchitis			
Pregnancy			
Recurrent back pain			
Severe headaches			
Surgeries			
Thyroid disease			
Other issues			

# COTTEY COLLEGE RECORD OF IMMUNIZATION

All students must submit completed health forms and immunization records with supporting documentation to Cottey College Health Services before your arrival on campus in August. **Residence hall check-in will be denied without completed forms.** Forms may be mailed to Cottey College, Health Services, 1000 W. Austin, Nevada, MO 64772 or faxed to (417) 448-1020.

Acceptable immunization documentation includes: Copies from physician's office, health department, high school, or previous college records.

**Student Name** \_\_\_\_\_  
**Cell Phone Number** \_\_\_\_\_

**Birth Date** \_\_\_\_\_  
**E-Mail Address** \_\_\_\_\_

<u>REQUIRED VACCINATIONS</u>	DATE	DATE	DATE	DATE
<b>MMR (measles, mumps, and rubella)</b>	_/_/___	_/_/___		
Two doses required at least 28 days apart for students born after 1956.				

<b>OR</b>				
<b>Measles</b>	_/_/___	_/_/___		
Two doses required.				
<b>Mumps</b>	_/_/___			
One dose required.				
<b>Rubella</b>	_/_/___			
One dose required.				

<b>Diphtheria-Pertussis-Tetanus</b>	_/_/___	_/_/___	_/_/___	_/_/___
Primary series, four doses acceptable.				

<b>Polio</b>	_/_/___	_/_/___	_/_/___	
Primary series, doses at least 28 days apart, three doses acceptable.				

<b>Tetanus Booster</b>	_/_/___			
Must be within past ten years.				

<b>Hepatitis B</b>	_/_/___	_/_/___	_/_/___	
Three doses required.				

<b>Varicella (chicken pox)</b> <b>No history of chicken pox requires vaccination.</b>		_/_/___	_/_/___	
Age at time of infection _____				

<b>Meningococcal</b>	_/_/___			
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<b>Tuberculosis Screening for All Students</b>	<b>Date Given</b>	<b>Date Read</b>	<b>Result</b>	
<i>All students must have a tuberculin skin test (TST) <b>before</b> arrival at Cottey and within the past six months.</i>	_/_/___	_/_/___	_____ mm	

**Chest X-Ray** \_\_\_\_\_

A **newly** positive skin test requires a chest x-ray with the written report submitted to Cottey College Health Services.

1. If the chest x-ray is negative, then preventative medication therapy (e.g., INH) is required and should be started before arrival at Cottey, with documentation submitted to Cottey College Health Services.
2. If the chest x-ray is positive for active pulmonary tuberculosis, then approval from the dean of student life is required.

A **previous** positive skin test and/or previous active tuberculosis requires documentation of medication therapy, a current negative chest x-ray, and/or negative sputum test sent to Cottey College Health Services.

<b><u>RECOMMENDED VACCINATIONS</u></b>				
<b>Hepatitis A</b>	_/_/___	_/_/___		
<b>Human Papillomavirus Vaccine (HPV)</b>	_/_/___	_/_/___	_/_/___	
<b>Influenza</b>	_/_/___			

**Student signature** \_\_\_\_\_ **Date** \_\_\_\_\_

# STUDENT HEALTH SERVICES CONSENT FORM

A medical history and immunization record are required of all new students by Cottey College.

Each student should make provisions for personal health insurance and costs for any medical treatment needed beyond that provided at the Health Services Office. With the exception of medications, which may be prescribed, and special tests which may be conducted when necessary, treatment at the College Health Services Office is provided without cost to the student. A physician provides health services for up to one hour each weekday. Health care services are provided only within the health care facility.

I grant permission for the health professionals who are engaged by Cottey College to render such health care as in their judgment seems advisable and to make necessary referrals to other physicians and facilities as indicated for this student in the event of illness or accident. Referrals may be made for lab work, x-rays, pelvic examinations, counseling, psychological or psychiatric services, or other services or consultations deemed appropriate.

In the event of any emergency requiring surgical treatment, I hereby grant permission to any surgeon designated by a College physician to perform surgery. I further consent to the administration of such anesthesia as may be considered necessary or desirable in the judgment of the surgeon.

I hereby accept financial responsibility for the expense of health care services which are considered necessary or desirable in the judgment of a College physician.

I certify that I have reviewed this form and that the information contained herein is true and complete.

\_\_\_\_\_  
Signature of student 18 years old or older

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of legally responsible parent/guardian if student under 18

\_\_\_\_\_  
Date