Missouri Valley College
Student Health Services
Casey Vogelsmier - Campus Nurse
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Student ID Number ____________________ Date of Birth ___________________

Name ____
Last First MI

Permanent Mailing Address (Home) ____
Street

____
City State Zip Cell Phone Number

Health Insurance Company ____
(Please provide/attach a copy of insurance card)

Student Health Form

Confidential Sharing Agreement and Consent for Treatment – The Missouri Valley College Student Health Record is required of all current MVC students/athletes. Missouri Valley Student Health Center assures that medical information will be regarded as confidential and shared only as necessary for the patient's immediate safety. The Clinic will not release medical information to parents unless the student signs a separate release of information. If a serious illness or accident should occur, every effort will be made to contact the individual listed as emergency contact. However, in the event that delay in medical or surgical treatment may be detrimental to the health of the student, authorization for consultation and treatment by area physicians, medical providers or EMS. Missouri Valley Student Health Center recognizes the importance of cooperating with the student's physicians, clinic, or hospital in providing health care. In order to secure or exchange health information, it is necessary to have the permission of the student. On occasion, information regarding physical or mental health status of a student may be shared with the vice president of student life or counseling staff if sharing that information would benefit the student. No information will be provided to faculty, coaches or work study. Permission is hereby granted to share health information with my physicians, clinic, hospital, vice president for student life, or counseling staff if this information would be beneficial to my health. The information will remain confidential in accordance with Family Educational Rights & Privacy Act (FERPA) (20 U.S.C. 1232g: 34 CFR Part 99)

Missed Classes - When a student is absent from class due to illness or injury, it is the responsibility of the student to communicate with his/her professor and to follow the requirements of the professor regarding the course work missed. Penalties for absenteeism depend upon the policy and discretion of the professor, as outlined in the course syllabus. Student Health Services will not issue any notes to excuse me from class, course-work, work or practice.

I Acknowledge and Agree - Right to refuse any procedure or treatment; no guarantees are made as to the effectiveness of treatment, I will use any prescribed or distributed medications for only the intended purpose per label instructions; I agree to be treated by SHS staff and/or their designees.
This form has been explained to me and I understand all of its contents.

____
Signature of patient Date

____
Signature of parent/guardian if patient is under age 18 Date

Medical History

Extended medical care: If you have had surgery, severe injuries (i.e. Motor vehicle accidents, fractures) or hospital stays, please comment here and include year.

____

____

Please list any medications you are currently taking: ______________________ Drug Allergies: (Please specify)____________

____

Any handicap or medical/physical condition which restricts your activity level and/or requires special adaptations:______________

Any medical issues (chronic illnesses or disease) the college should be aware of? (Please specify):______________

____

Are you now receiving or have you ever received treatment for mental health or alcohol/drug treatment? ❑ Yes ❑ No

If yes, please specify ____

Student Health Form, continued

Immunizations - Please enter date in month, day, year format (mm/dd/yyyy). Official documentation of your immunization records must also be attached. These can include copies of medical records, school records, officially signed immunization cards and insurance receipts. Your immunizations will not be considered valid and will not be entered into the computer system without official documentation. **Must be in English language (No originals/copies only)**

Tetanus/Diphtheria/Pertussis: 1 dose of adult Tdap. If last Tdap is more than 10 years old, provide date of last Td and Tdap.

Td	Mo./day/year	Mo./day/year	Mo./day/year	Mo./day/year
Tdap booster **Must have one documented	Mo./day/year			

Measles/Mumps/Rubella: Two doses (required of all students born after December 31, 1956) | For those born before December 31, 1956. (History of disease) Lab titers done at your expense. Lab copy must be attached in order to be accepted **OR** written statement from Health Care Provider assuring diagnosed case of measles, mumps and rubella; documentation from baby book.

MMR - 2 Required on or after 1st birthday	(#1) Mo./day/year	(#2) Mo./day/year	
OR			
Measles - 2 Required on or after 1st birthday	(#1) Mo./day/year	(#2) Mo./day/year	
Mumps - 2 Required on or after 1st birthday	(#1) Mo./day/year	(#2) Mo./day/year	
Rubella - 1 required on or after 1st birthday	Mo./day/year		
OR			
MMR Titer *must attach laboratory results	Date of Titer	Results	

Meningococcal Quadrivalent: One or 2 doses for all students, revaccinate every 5 years if increased risk continues.

Quadrivalent Conjugate (preferred; administered simultaneously with TDaP if possible)	(#1) Mo./day/year	(#2) Mo./day/year	
Quadrivalent Polysaccharide (acceptable alternative if conjugate not available)	Mo./day/year		

Student Health Form, continued

Tuberculosis Information

All students are required to complete the below questionnaire yearly.

Check any that apply:

❑ Yes ❑ No Have you ever had a positive TB test or been treated for TB?

❑ Yes ❑ No Have you had contact with a person known to have active tuberculosis.

❑ Yes ❑ No Have you ever traveled to/or lived in one or more of the countries listed below?

❑ Yes ❑ No Do you have symptoms of active tuberculosis, such as unexplained weight loss or weakness, coughing up blood or night sweats.

❑ Yes ❑ No Have you ever been vaccinated with BCG?

❑ Yes ❑ No Were you born in one of the countries listed below and/or arrived in the US within the past 5 years?

Circle all that apply:

Afghanistan	Congo	Kazakhstan	Myanmar	South Africa
Algeria	Cook Islands	Kenya	Namibia	Sri Lanka
Angola	Cote d'Ivoire	Kiribati	Nepal	Sudan
Argentina	Croatia	Korea (Republic of)	Nicaragua	Suriname
Armenia	Djibouti	Kuwait	Niger	Swaziland
Azerbaijan	Dominican Rep.	Kyrgyzstan	Nigeria	Syrian Arab Republic
Bahrain	Ecuador	Lao People's Democratic	Pakistan	Tajikistan
Bangladesh	El Salvador	Rep.	Palau	Tanzania (United Rep of)
Belarus	Equatorial Guinea	Latvia	Panama	Thailand
Belize	Eritrea	Lesotho	Papua New Guinea	Timor-Leste
Benin	Estonia	Liberia	Paraguay	Togo
Bhutan	Ethiopia	Libyan Arab Jamahiriya	Peru	Tonga
Bolivia	French Polynesia	Lithuania	Philippines	Trinidad & Tobago
Bosnia/Herzegovina	Gabon	Macedonia (Republic of)	Poland	Tunisia
Botswana	Gambia	Madagascar	Portugal	Turkey
Brazil	Georgia	Malawi	Qatar	Turkmenistan
Brunei Darussalam	Ghana	Malaysia	Romania	Tuvalu
Bulgaria	Guam	Maldives	Russian Federation	Uganda
Burkina Faso	Guatemala	Mali	Rwanda	Ukraine
Burundi	Guinea	Marshall Islands	Saint Vincent & Grenadines	Uruguay
Cambodia	Guinea-Bissau	Mauritania	Sao Tome & Principe	Uzbekistan
Cameroon	Guyana	Mauritius	Senegal	Vanuatu
Cape Verde	Haiti	Micronesia	Serbia	Venezuela
Central African Republic	Honduras	Moldova (Republic of)	Seychelles	Viet Nam
Chad	India	Mongolia	Sierra Leone	Yemen
China	Indonesia	Montenegro	Singapore	Zambia
Colombia	Iraq	Morocco	Solomon Islands	Zimbabwe
Comoros	Japan	Mozambique	Somalia	

** The significance of the travel exposures should be discussed with a health care provider and evaluated**

(**) Categories of high-risk students include those students who have arrived within the past five years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts, Nevis, St. Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Italy, Liechtenstein, Luxemborg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other categories of high-risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters, and those who have clinical conditions such as diabetes, chronic renal failure, leukemia's or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone 15mg/d for 1 month) or other immunosuppressive disorders.

If you answered YES to any of the above questions, Missouri Valley College requires that you receive TB testing as soon as possible but at least prior to the start of each semester. Missouri Valley College offers TB Skin Testing for a small fee. If you have been treated for TB please provide records.

If you answered NO to all the above questions, no further testing or further action is required.

Signature____ Date____________________

Please print name, student ID number, and date of birth below.

Name ______________________________

Student ID Number ______________________________

Date of Birth ______________________________

Student Health Form, continued

Tuberculosis Skin Test (TST): Chest X-Ray or IGRA required if previous vaccination of BCG or a positive TST.

Tuberculin Skin Test | Placed within the past 12 months | 2 Step TST for those at high risk that have no documentation of a previous TST. The 2nd test must be placed at least 1 week after the 1st TST read date.			
1st TST Place date	1st TST Read date	2nd TST Place date	2nd TST Read date
		*If needed	
OR			
IGRA TB Screening *must attach laboratory results _ T-spot _ Quantiferon Gold	Date of IGRA	Result	
Chest X-Ray (Please include a copy of the report or written verification by the physician)	Normal ❑	Abnormal ❑	Date Completed:___________

Have you ever been treated with Isoniazid Yes ❑ No ❑ If so, for how long ____

Healthcare Provider Certification (*Licensed Medical Doctor/Nurse Practitioner) - If immunization section was filled out by a Health Care Provider

Full Name ____

Address ____
Street

____
City State Zip

Phone Number ____

Provider/Clinic Stamp (If available)

____
Signature Date