

To: New Cornell Students
From: Student Health Services
Re: Your Health Forms

The Health Center Staff welcomes you to Cornell College! We are here to support you in any way possible during your years at Cornell. If you have a special need or require assistance with a medical problem, please contact us at (319) 895-4292 or e-mail us at student_health@cornellcollege.edu

Please download and complete the online health forms and **return by JULY 31, 2011** to:

Student Health Services
Cornell College
600 First Street SW
Mount Vernon, Iowa, 52314

The forms could also be scanned and emailed to student_health@cornellcollege.edu.

The health forms are a requirement for admission. Students not in compliance will have their course registration cancelled. Medical forms are strictly confidential and are used by the Health Service to provide care. The content of your medical record has no effect on your admission status.

Based on The Centers for Disease Control and the American College Health Association guidelines, Cornell College requires all enrolled students to have proof of two MMR (measles, mumps, rubella) immunizations. Proof of natural immunity through documentation of physician diagnosed disease or a positive serum titer may be substituted in place of vaccination documentation. No other immunizations are required for admittance; however, it is recommended that students consider the following vaccines: Meningitis, Hepatitis B, HPV, Chicken Pox and Tetanus. Please consult your clinician regarding these vaccines. Some of these vaccines are also available at Cornell College Student Health. **If any student comes to college without documented proof of proper MMR immunization, their registration will be cancelled.**

CHECKLIST

- Family history and medical history** – to be completed by the student before seeing a health care provider for a physical exam (pages 1- 2).
- Required immunizations-** You are required to have documentation of 2 MMR's.
- Have you considered the highly recommended meningitis vaccine?** Please read the online informational sheet (the last page of your online health forms) and sign the box on page 2. Please discuss this with your health care provider to make your decision and/or to determine if you need a booster. Meningitis vaccine is also available at Cornell Student Health.
- Required physical exam** – Physicals must be current within one year prior to the beginning of the first day of classes – September 5, 2011.
- Are you participating in NCAA sports?** Did you sign the release of information at the bottom of page one?
- Medical Insurance** – Did you copy your insurance card (front and back) on page 5 and make a copy for yourself to carry while away at college? Check to make sure your primary insurance covers you while at college, especially if you are from out of state.

Cornell College Student Health Services
600 First St. SW
Mt. Vernon, IA 52314

Phone: 319-895-4292

email: student_health@cornellcollege.edu

This page to be completed by the student

Last Name:	First Name:	Middle:	Sex:
Date of Birth (MM-DD-YY)	Social Security #:	Student email address:	
Parent Names (or emergency contact)		Parent Home Phone:	
Work Phone:		Parent Cell Phone:	
Street Address	City	State	Country Zip Code

Allergy to Medication(s): _____ Allergy to food or environmental allergens: _____

Medications you are taking (please include all prescription, nonprescription and herbal medications and their dosages):

1) _____ 2) _____ 3) _____
 4) _____ 5) _____ 6) _____

Medical, emotional or health conditions (please list): _____

Special needs or disability? _____

Family History

	Birthdate	State of Health	Occupation	Age of death	Cause of death
Parent					
Parent					
Siblings					

C For all students: By signature, I give consent to have the information on this form released to the Dean of Students
O and/or her designee for emergency use only.
N
S
E _____
N Student Signature (Parent/Guardian signature only if student is a minor) Date
T

All Cornell students are required to have health insurance that covers them while at college. Please check with your carrier to make sure you have coverage while away from home, especially if you are from out of state. Specific arrangements may need to be made to establish guest benefits or out-of-area coverage. Cornell College offers a supplemental policy. For further information contact the Business Office at 319-895-4220, or go to www.cornellcollege.edu/student_health.
Please attach a photocopy of the front and back of your insurance card. In addition, each student should carry a copy of their own insurance card. Contact your carrier if an additional card is needed.

Health History **Last Name** _____ **First Name** _____

The information on the Health History and Physical Examination forms is legally privileged and confidential and is intended for the use of the Cornell College Student Health Services. It cannot be copied or transmitted without the student's written consent.

Medical or Health Concerns (Please check any that apply to you, and explain positives below.)

Abnormal Bleeding	Depression	Heat stroke/Sun stroke	Scoliosis
Anemia	Diabetes	Hernia	Seizures
Anxiety	Disability	High Blood Pressure	Sickle cell trait
Arthritis	Ear trouble/Hearing loss	High cholesterol	Single organ
Asthma	Eating disorder	Immune deficiency	Sinus trouble
ADD/ADHD	Eye trouble/visual loss	Intestinal/Stomach trouble	Spleen (surgical removal)
Cancer	Fractures (including stress)	Joint injury (sprain/dislocation)	Syncope / Fainting
Chest pain	Genetic disorder	Kidney disease	Thyroid disease
Chicken pox**	Headaches – (recurrent)	Mononucleosis	Tobacco use
Concussion / Head injury***	Heart murmur	Orthopedic problem (chronic)	Tuberculosis
*** If yes, how many concussions in your lifetime?	Heart problems (other)	Rheumatic fever	Undescended testicle
Convulsive disorder	Hepatitis		Other:

Explain positives:

**If you have had chicken pox, please note in this section.

***If you have had one or more head injuries, please note details in this section.

Have you ever... Answer yes or no (if yes, give details)

...been hospitalized or had any serious illness or injury? ...had surgery?

...received or are you now receiving treatment or counseling for mental health reasons or alcohol/drug problems?

Consent for treatment:

TO BE SIGNED BY STUDENT: (IF STUDENT IS A MINOR, PARENT/LEGAL GUARDIAN SIGNATURE ALSO REQUIRED.)

In case of serious illness or accident, I give Cornell College or its representative(s) permission to secure emergency medical and/or surgical care that is considered necessary. I agree to pay all medical costs.

Student signature

Parent/Guardian signature only if student is a minor Date

Meningitis Information Statement: Important Please Read

TO BE SIGNED BY STUDENT: (IF STUDENT IS A MINOR, PARENT/LEGAL GUARDIAN SIGNATURE ALSO REQUIRED.)

My signature below indicates that I have read the meningitis information, found on the final page of the online health forms, regarding meningitis risk to college students. I am aware that a vaccine is available for the prevention of certain types of meningitis, and that the vaccine is recommended for college freshman and other college students who may want to decrease their risk of contracting meningitis. I am also aware that if I had this shot prior to age 15, I will need a booster.

Student signature

Parent/Guardian signature only if student is a minor Date

For NCAA athletes only: *By signature, I authorize Cornell College Student Health Services to release of a copy of my history and physical to the Cornell College Athletic Training Staff.*

Circle which sport(s) you plan to participate in - **Cheerleading** **Golf** **Track and Field** **Football** **Tennis**
Cross Country **Volleyball** **Soccer** **Basketball** **Wrestling** **Baseball** **Softball**

Athlete's signature

Parent/Guardian signature only if student is a minor Date

Physical Examination (To be completed by clinician)

To the Examiner: Please review the student's report and complete this physical exam form with comments on all positive answers. Since this student has already been accepted for admission, the information supplied will not affect his or her status and will be used only as background for providing any needed care by Cornell College Student Health Services. It will not be released without the student's consent. **The completed form should be given to the student, who will return it to the College.**

Name _____
Last First Middle
 Birthdate _____ Sex _____ Height _____ Weight _____
 BP _____ Pulse _____ UA - Sugar _____ Albumin _____ Micro _____
 Sickle Cell Trait (*required for all athletes*) _____
 Hemoglobin (*if indicated*) _____ gms Peak Flow (*if indicated*) _____ L/m

Are there any abnormalities of the following systems?

	No	Yes	Describe
Eyes			
Head, ENT			
Cardiovascular			
Respiratory			
Breast			
Gastrointestinal			
Genitourinary			
Hernia			
Musculoskeletal			
Metabolic/Endocrine			
Skin			
Neuropsychiatric			

How long have you known the student? _____

ALLERGIES: _____

Medications:

- 1) _____ 2) _____
 3) _____ 4) _____

Recommendations for physical activity (P.E., intramurals or varsity athletics) Unlimited Limited Explanation _____

Do you have any recommendations regarding the care of this student? Yes No If so, what? _____

Is the patient now under treatment for any medical condition? Yes No Diagnosis _____

Is the patient now under treatment for any emotional condition? Yes No Diagnosis _____

General comments: _____

Provider's Signature _____

Date _____

Phone _____

Immunizations REQUIRED

Measles/Mumps/Rubella **Dates**
 (Two MMR's required)

Dose #1 (month/day/year) _____
 Dose #2 (month/day/year) _____

Immunizations RECOMMENDED

Meningococcal #1 _____ #2 _____
**Highly recommended - Please read and sign statement on page 2.*

Tetanus/Diphtheria or Adacel (circle)
 Date series completed _____
 Most recent booster _____

Polio (series, completed) _____
 Adult booster _____

Hepatitis A #1 _____ #2 _____

Hepatitis B
 #1 _____ #2 _____ #3 _____

Chicken Pox/Varicella _____
 Did student have disease? Y N

Gardasil
 #1 _____ #2 _____ #3 _____

Other

Provider's Clinic Stamp Here:



Tuberculosis (TB) Risk Assessment : Name: _____ Birthdate _____

To be completed by your healthcare provider. Persons with any of the following are candidates for either Mantoux tuberculin skin test or Interferon Gamma Release Assay, unless a previous positive test has been documented.

Persons with no known risk factors should complete this form, but **DO NOT** need testing.

Risk Factors

Recent close contact with someone with infectious TB disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Foreign-born from, or travel to endemic region (Africa, Asia, Eastern Europe, Central or South America)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
HIV/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Organ transplant recipient	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Immunosuppressed (equivalent of >15mg/day of prednisone for > 1 month, or TNF-a antagonist)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of illicit drug use	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Resident, employee, or volunteer in a high-risk congregate setting (e.g. correctional facilities, nursing homes, homeless shelters, hospitals, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medical condition associated with increased risk of progressing to TB disease if infected - list name of disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the student have signs or symptoms of active tuberculosis disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If **No** to all of the above, no testing is needed. . If **Yes** to any question, proceed with additional evaluation to exclude active or latent tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

1. Tuberculin Skin Test (TST) – should be recorded as millimeters of induration, transverse diameter*

Date given: / / Site: L R forearm Date read: / / Result: mm induration

Date given: / / Site: L R forearm Date read: / / Result: mm induration

2. Interferon Gamma Release Assay (IGRA)

Date obtained: / / Method: _____ Result: Negative___ Positive___ Intermediate___

Date obtained: / / Method: _____ Result: Negative___ Positive___ Intermediate___

3. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: / / Result: normal___ abnormal___ (please specify)
M D Y

Signature of clinician completing this form _____ Date: / /
M D Y

*Interpretation guidelines

>5mm is positive:

- Recent close contacts of an individual with infectious TB
- Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
- Organ transplant recipients
- Immunosuppressed persons: taking >15 mg/d of prednisone for >1 month, taking a TNF-a antagonist
- Persons with HIV/AIDS

>10mm is positive:

- Persons born in a high prevalence country or who resided in one for a significant amount of time
- History of illicit drug use
- Mycobacteriology laboratory personnel
- History of resident, worker or volunteer in high-risk congregate setting
- Medical condition associated with increased risk of progressing to TB disease

>15 mm is positive:

- Persons with no known risk factors for TB disease

Please copy front **and back** of your insurance card here:
(Students should also carry a copy of their card.)

A large, empty rectangular box with a thin black border, occupying most of the page below the text. It is intended for students to paste a copy of their insurance card into.

Meningococcal Disease Information

*****Note – If you received this vaccine earlier, you may now need a booster –see below.**

In 2011, the U.S. Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) issued new recommendations for the meningitis vaccination schedule.

2011 Recommendations:

1. The initial vaccine should be given at 11-12 years of age with a booster dose given at 16 years of age.
2. If the initial vaccine is given at 13-15 years of age, a booster dose should be given at 16-18 years of age.
3. If the initial vaccine is given at 16 years of age or older, no booster dose is required.

College Students at Special Risk - Adolescents 11-18 years of age and other populations at increased risk, including college students living in residence halls/similar housing, etc., should receive the vaccine. Non-freshman college students who wish to decrease their risk of meningococcal disease may also choose to be vaccinated.

Facts about Meningitis -Meningococcal disease is a rare, but dangerous bacterial infection that causes meningitis and blood poisoning. In the U.S., ten-year data (1998-2007) show an average incidence of 1,500 cases per year. Adolescents and young adults are at increased risk for the disease. About 11 percent of people of any age who are infected will die, even with appropriate treatment. Among adolescents and young adults, the case fatality rate is 10 to 14 percent. Of those who survive, up to 19 percent will endure permanent disability including limb loss, hearing loss and brain damage. The majority of cases among adolescents are vaccine preventable.

How Meningitis is Spread - Meningococcal disease is transmitted through the exchange of respiratory and throat secretions, and close, personal contact.

Be Alert: Early Flu-Like Symptoms - Symptoms can be mistaken for the flu and may include fever, headache, stiff neck, vomiting, sensitivity to light, confusion and rash. Meningococcal disease can progress very rapidly and can kill an otherwise healthy young person in 48 hours or less.

Consider Vaccination - Vaccination is the best method of prevention against meningococcal disease. Immunization can prevent up to 80 percent of meningococcal meningitis cases in adolescents and young adults. The vaccine is safe and effective against four of the five types of the bacteria responsible for meningococcal meningitis. There are risks associated with all vaccines. The meningococcal vaccine can cause pain, redness, and swelling at the injection site; headache; fatigue; and malaise.

For more information about meningococcal disease and immunization, visit the following web sites:

www.cdc.gov/meningitis

www.voicesofmeningitis.com

www.nmaus.org