

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, 2010** to:

New Student Orientation
Cornell College
600 First Street SW
Mount Vernon, Iowa, 52314

The forms could also be faxed to: 319-895-5894 or scanned 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. 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 – August 30, 2010.
- 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
Fax: 319-895-5894
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:	
				Student cell phone:	
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:
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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					

<p>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.</p>		
<p>N S E _____ N Student Signature (Parent/Guardian signature only if student is a minor) Date T</p>		

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.

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 _____

Blood Pressure _____ Pulse _____ Height _____ inches

Urinalysis Sugar _____ Albumin _____ Micro _____ Weight _____ pounds

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 _____
 *Highly recommended – Please read and sign statement on page 2.

Tetanus/Diphtheria or Adacel (circle) _____
 (most recent booster)

Polio (series, completed) _____

Hepatitis A #1 _____ #2 _____

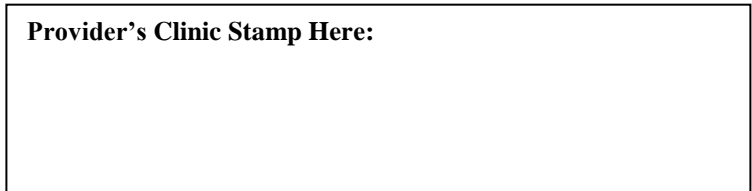
Hepatitis B
 #1 _____ #2 _____ #3 _____

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, intended for students to paste a copy of their insurance card. The box occupies most of the page below the instructions.