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

The Health Center Staff welcomes you to Cornell College! We are here to support you in any way possible during your time 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 Nancy Reasland, Director of Health Services, at nreasland@cornellcollege.edu.

The college requires that all students have a current health history, physical, and record of immunization* on file in the Student Health Services office. *Students not in compliance will have their course registration cancelled for Block 2.* Medical forms are strictly confidential and are used by the Health Service team to provide care; the content of your medical record has no effect on your admission status.

Please download and complete the health forms**. The completed forms should be uploaded to the student's online checklist via the student portal by July 31st.** Alternately, they may be mailed to the following address. Be sure to keep a copy for your records.

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

*Based on The Centers for Disease Control and the American College Health Association guidelines, Cornell College requires all enrolled students to have proof of one Meningitis Quadrivalent Vaccine (A,C,Y,W-135) on or after the student's 16th birthday, and two MMR (measles, mumps, rubella) immunizations given at least 1 month apart. Proof of natural immunity through documentation of positive mumps, measles, rubella and meningitis serum titers may be substituted in place of vaccination documentation. No other immunizations are required for admittance; however, it is highly recommended that students receive the following vaccines: Hepatitis B, Meningitis B, HPV, Chicken Pox and TDAP. Please consult your clinician regarding these vaccines.

Health Forms Checklist

☐ **Family and Medical History** (pages 1-2): To be completed by the student before seeing a health care provider for a physical exam. Please be sure you have signed all consent sections. An electronic signature is not accepted.

☐ **Physical Exam** (page 3): Physicals must be current within one year prior to the beginning of the first day of classes (page 3).

☐ **Required Immunizations** (page 4): You are required to present documentation of:

- 2 MMR vaccines
- 1 Meningitis (Quadrivalent ACYW-135) vaccine given on or after the student's 16th birthday

Students without documentation of MMR and Meningitis immune status will have their registration cancelled!

☐ **Medical Insurance**: **Please verify that your insurance covers you while at college,** especially if you are from out of state. Be sure to copy the front and back of your insurance card on page 5 of the forms and make a copy for yourself to carry as well. If you do not currently have insurance, we encourage you to check out Healthcare.gov for insurance rates through the Marketplace or look into private coverage.

☐ **Student Athletes**: Please indicate the sport in which you will participate, and sign the Release of Information at the bottom of Page 2 so that the Athletic Department can have a copy of your physical.

To consider: The Meningitis B vaccine is also strongly recommended for all college students. This vaccine is different from the required ACYW-135 vaccine. Please discuss meningitis vaccination with your health care provider at the time of your physical. More information about this potentially fatal disease and how to prevent it can be found at https://www.cdc.gov/meningococcal/.

Please return forms by July 31st.

Cornell College Student Health Services **Phone: 319-895-4292**
600 First St. SW **Fax: 319-895-5894**
Mt. Vernon, Iowa 52314 **email: healthservices@cornellcollege.edu**

This page to be completed by the student

Last Name:	First Name:	Middle:	Gender at birth: M F Identify as: M F Other
Date of Birth (MM-DD-YY)	Social Security #:	Student email address:	
		Student cell phone:	
Parent Names (or emergency contact)		Parent Contact Information: Cell phone: Work Phone: Alternate Phone:	

Street Address City State Country Zip Code

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

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

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

Do you have any health or emotional conditions (e.g. asthma, anxiety, depression, etc.)? Please list.

Do you have any special needs or disabilities? Please list.

Family History – *Please include all immediate family members regardless of health status.*

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

CONSENT: For all students: *By signature, I give consent to have the information on this page only released to the Ambulance team or the Dean of Students and/or the Dean's designee* ***only in case of emergency****.*

_____ _____
Student Signature (Parent/Guardian signature only if student is a minor) Date

Last Name_____ First Name_____ Birthdate _____

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.)**

ADD/ADHD		Depression		Heart Condition		Scoliosis	
Anemia		Diabetes – Indicate Type		Hepatitis		Seizures	
Atypical Bleeding/Clotting		Disability		Heat Stroke/Sun Stroke		Sickle Cell Trait/Disease	
Anxiety		Ear Trouble/Hearing Loss		Hernia		Sinus Trouble	
Arthritis		Dislocations/Fractures		High Blood Pressure		Skin Condition	
Asthma		Disordered Eating		High Cholesterol		Sleep Disorder	
Autoimmune Disorder		Drug/Alcohol Treatment		Intestinal/Stomach Disorder		Syncope (Fainting)	
Bladder Infections		Eye Trouble/Vision Loss		Kidney Disease/Stones		Thyroid Disease	
Cancer		Fibromyalgia		Mononucleosis		Tobacco Use	
Chest Pain		Gynecological Condition		Orthopedic Problem (Chronic)		Tuberculosis	
Chicken Pox		Headaches (Indicate type)		POTS		Undescended Testicle	
Concussion/Head Injury***		Heart Murmur		Rheumatic Fever		**Other:**	

If you have checked any of the boxes above or another condition not mentioned, please note details here:

***How many concussions have you had in your lifetime?_____ Please note details below:

Have you ever been hospitalized or had any serious illness, injury or surgery? Yes No Please note details below:

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 - must sign | Parent/Guardian signature only if student is a minor | Date

For NCAA athletes only: *By signature, I authorize Health Services to release of a copy of my history and physical to the Cornell College Athletic Training Staff.* ***Please circle below the NCAA sport(s) in which you will be participating.***

_____ _____ _____

Athlete's signature – circle sport below | *Parent/Guardian signature only if student is a minor* | Date

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

Insurance information: **It is strongly recommended that each student has health insurance that covers them in Mt. Vernon, Iowa.** Cornell College does not offer an insurance policy for domestic students. The Affordable Care Act allows students to stay on their parents' policy through age 26. 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 with your company to establish out-of-area coverage. All students should carry a copy of their own insurance card! Contact your carrier if an additional card is needed.

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.
The completed form should be given to the student, who will return it to Health Services as instructed!

Patient's Name _____
Last *First* *Middle*

Birthdate _____ Assigned sex at birth *Male Female* Gender Identity (circle one) *Male Female Transgender*

BP _____ Pulse_____ Height_____ Weight_____ Vision _____

ALL athletes must be screened for sickle cell trait, show proof of a prior test, or sign a waiver on arrival on campus releasing Cornell athletics from liability if decline to be tested.
Sickle Cell Solubility Test/Screen (if indicated) _____ Screening declined _____

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 TO MEDICATIONS: _____
CURRENT MEDICATIONS:
1)_____ 2)_____ 3) _____
4)_____ 5)_____ 6)_____

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:_____

PLEASE NOTE: IMMUNIZATIONS SHOULD BE RECORDED ON PAGE 4

Provider's Signature_____

Date _____

Phone_____

Provider's Clinic Stamp Here:

Cornell College

STUDENT HEALTH CENTER, 600 1ST ST. SW, MT. VERNON, IA 52314

CERTIFICATE OF IMMUNIZATION

Name _____

Date of Birth _____ Social Security Number _____ - _____ - _____

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER (must be in English)

REQUIRED Immunizations – *registration will be held until documentation of required vaccines is received.*		
The following vaccines are required:	**Date vaccine given** (MM/DD/YR)	**Clinic or Public Health Department**
Mumps/Measles/Rubella (MMR) *2 doses required*	1.	
	2.	
Meningococcal-ACYW-135 *(Menactra/Menveo/Nimenrix) 1 dose at age 16 or after is required*	1.	
	2.	
Proof of natural immunity through documentation of positive mumps, measles, rubella and meningitis serum titers may be substituted in place of vaccination documentation. Please attach supporting labs.		
RECOMMENDED Immunizations		
Tetanus/Diptheria (DTaP/DTP/DT/Td/Tdap)	1.	
	2.	
	3.	
	4.	
	5.	
Polio (IPV/OPV)	1.	
	2.	
	3.	
	4.	
	5.	
Hepatitis B	1.	
	2	
	3.	
Varicella (Chicken Pox)	1.	
	2.	
Meningitis B (*Trumenba, Bexsero*) Serogroup B accounts for approximately 40% of meningitis cases on college campuses. For more information: http://www.nmaus.org/	1.	
	2.	
HPV (Human Papilloma Virus)	1.	
	2.	
	3.	
OTHER Immunizations		
Hepatitis A	1.	
	2.	
Typhoid (oral or injectable – please indicate)		
Other		

I certify that this document has been completed to the best of my knowledge.

_____ _____ _____

Signature of Certified Medical Provider | Date | Clinic or Public Health Agency

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	☐ Yes	☐ No
Foreign-born from, or travel to endemic region (Africa, Asia, Russia, Eastern Europe, Central or South America)	☐ Yes	☐ No
Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Organ transplant recipient	☐ Yes	☐ No
Immunosuppressed (equivalent of >15mg/day of prednisone for > 1 month, or TNF-a antagonist)	☐ Yes	☐ No
History of illicit drug use	☐ Yes	☐ No
Resident, employee, or volunteer in a high-risk congregate setting (e.g. correctional facilities, nursing homes, homeless shelters, hospitals, etc.)	☐ Yes	☐ No
Medical condition associated with increased risk of progressing to TB disease if infected - list name of disease _____	☐ Yes	☐ No
Does the student have signs or symptoms of active tuberculosis disease?	☐ Yes	☐ 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: ___/___/___ (M D Y) Site: L R forearm Date read: ___/___/___ (M D Y) Result: ____mm induration

Date given: ___/___/___ (M D Y) Site: L R forearm Date read: ___/___/___ (M D Y) Result: ____mm induration

2. Interferon Gamma Release Assay (IGRA)

Date obtained: ___/___/___ (M D Y) Method: _____ Result: Negative___ Positive___ Intermediate___

Date obtained: ___/___/___ (M D Y) Method: _____ Result: Negative___ Positive___ Intermediate___

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

Date of chest x-ray: ___/___/___ (M D Y) Result: normal____ abnormal_____ (please specify)

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**

- ❑ I have copied the front and back of my insurance card on this page. (I understand I should obtain and carry a copy of my card with me.)

- ❑ I currently do not have health insurance. (Please go to https://www.healthcare.gov/ for more information on health insurance and coverage options. Insurance is strongly encouraged.)

Insurance information: <u>It is strongly recommended that each student has health insurance that covers them in Mt. Vernon, Iowa</u>. Cornell College does not offer an insurance policy for domestic students. The Affordable Care Act allows students to stay on their parents' policy through age 26. 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 with your company to establish out-of-area coverage. All students should carry a copy of their own insurance card! Contact your carrier if an additional card is needed.

Copy front and back of insurance card here. *Students should carry a copy of their card with them!*