

**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 the Student Health Center at [student\\_health@cornellcollege.edu](mailto:student_health@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 August 10th.** Alternately, they may be mailed to the following address. Be sure to keep a copy for your records. **NOTE:** *The Student Health Center is closed in the summer. You will not receive immediate notification that your forms have been received. Once they are processed, your checklist will be updated. Forms will be processed beginning August 1<sup>st</sup>.*

**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 16<sup>th</sup> 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, COVID and TDAP. Please consult your clinician regarding these vaccines.

### Health Forms Checklist

- Family and Medical History:** 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:** Physicals must be current within one year prior to the beginning of the first day of class.
- Required Immunizations:** You are required to present documentation of:
  - 2 MMR vaccines
  - 1 Meningitis (Quadrivalent ACYW-135) vaccine given on or after the student's 16<sup>th</sup> 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 submit a copy the front and back of your insurance card 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](https://www.healthcare.gov) for insurance rates through the Marketplace or look into private coverage.
- Student Athletes:** Please indicate the sport in which you will participate on your medical history, and sign the Release of Information 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 Aug. 10th. Forms will be processed beginning Aug. 1<sup>st</sup>.**

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

**Phone: 319-895-4292**  
**Fax: 319-895-5894**  
**email: healthservices@cornellcollege.edu**

*This page to be completed by the student*

Last Name:	First Name:	Middle:	Gender at birth: M F Nonbinary Identify as: M F Nonbinary Other: Preferred pronouns:			
Date of Birth (MM-DD-YY)	Preferred Name (Nickname)	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) _____						
Please list all health and/or emotional conditions :						
Do you have any special needs or disabilities? Please list.						
Family History – <i>Please include all immediate family members regardless of health status.</i>						
	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
Asthma	Dislocations/Fractures	High Blood Pressure	Skin Condition
Autoimmune Disorder	Disordered Eating	High Cholesterol	Sleep Disorder
Bladder Infections	Drug/Alcohol Treatment	Intestinal/Stomach Disorder	Syncope (Fainting)
Cancer	Eye Trouble/Vision Loss	Kidney Disease/Stones	Thyroid Disease
Chest Pain	Fibromyalgia	Mononucleosis	Tobacco Use
Chicken Pox	Gynecological Condition	Orthopedic Problem (Chronic)	Tuberculosis
Concussion/Head Injury***	Headaches (Indicate type)	POTS	Undescended Testicle
COVID-19	Heart Murmur	Rheumatic Fever	<b>Other:</b>

**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:

Adequate sleep is crucial for success in college. How many hours of sleep do you get per night? \_\_\_\_\_  
Do you have difficulty sleeping? Yes No Comments:

**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. 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. Cornell College provides a small supplemental plan through EIIA, however this does not replace your insurance.

**Physical Examination for Cornell College** (To be completed by MD, DO, NP or PA)

**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) *M F N T*

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			

Does the student have any concerns about their sleep quality or quantity? \_\_\_\_\_

Were any sleep issues addressed today? \_\_\_\_\_

How long have you known the student? \_\_\_\_\_

**ALLERGIES TO MEDICATIONS:** \_\_\_\_\_

**CURRENT MEDICATIONS:**

1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

4) \_\_\_\_\_ 5) \_\_\_\_\_ 6) \_\_\_\_\_

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

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

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

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

General comments: \_\_\_\_\_

**Provider's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Phone** \_\_\_\_\_

**Provider's Clinic Stamp Here:**



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
<b>Mumps/Measles/Rubella (MMR)</b> <i>2 doses required</i>	1.	
	2.	
<b>Meningococcal-ACYW-135</b> ( <i>Menactra/Menveo/Nimenrix</i> ) <i>1 dose at age 16 or after is required</i>	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**

<b>Tetanus/Diphtheria (DTaP/DTP/DT/Td/Tdap)</b>	1.	
	2.	
	3.	
	4.	
	5.	
<b>Polio (IPV/OPV)</b>	1.	
	2.	
	3.	
	4.	
	5.	
<b>Hepatitis B</b>	1.	
	2.	
	3.	
<b>Varicella (Chicken Pox)</b>	1.	
	2.	
<b>Meningitis B</b> ( <i>Trumenba, Bexsero</i> ) Serogroup B accounts for approximately 40% of meningitis cases on college campuses. For more information: <a href="http://www.nmaus.org/">http://www.nmaus.org/</a>	1.	
	2.	
<b>HPV (Human Papilloma Virus)</b>	1.	
	2.	
	3.	
<b>COVID-19</b>	1.	
	2.	

**OTHER Immunizations**

<b>Hepatitis A</b>	1.	
	2.	
<b>Typhoid (oral or injectable – please indicate)</b>		
<b>Other</b>		

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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Foreign-born from, or travel to endemic region (Africa, Asia, Russia, 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

- 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: It is strongly recommended that each student has health insurance that covers them in Mt. Vernon, Iowa.** 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. Cornell College provides a small supplemental plan through EIIA, however this does not replace your insurance.

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