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 Student Health Services at 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 Aug. 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 1st.

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

Health Forms Checklist

☐ **Family and Medical History**: To be completed by the student before seeing a health care provider for a physical exam.

☐ **Physical Exam**: Physicals must be current within one year prior to the beginning of the first day of classes. The physical must be performed by a licensed healthcare clinician and written in English.

☐ **Required Immunizations**: You are required to present documentation of:
- 2 MMR (Mumps, Measles, Rubella) vaccines given at least 30 days apart
- 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!

☐ **No tuberculin testing prior to arrival**: ***Students from endemic regions should not have TB testing prior to arrival on campus.*** Testing will be done upon arrival at no expense to the student.

☐ **Student Athletes**: If you are participating in an NCAA sport, please indicate which sport and sign the Release of Information at the bottom of Page 2.

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/.

Health insurance: All international students will be automatically billed for health insurance through Cornell College. No other health insurance policy will be accepted. More information will be sent to you via your Cornell email address over the summer.

Please return forms by Aug. 10th. Forms will be processed beginning Aug. 1st.

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

This page to be completed by the student

Last Name (Family Name):	First Name (Given Name):	Middle:	Gender at birth: M F Identify as: M F T N Other: Preferred pronouns:
Date of Birth (MM-DD-YY)	Preferred Name (Nickname):	Student email address:	
		Student cell phone:	
Parent Names (or emergency contact) Work Phone:		Parent Home Phone: Parent Cell Phone:	

Street Address City State/Province Country Zip Code

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

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

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

List all health and/or emotional conditions:

Special needs or disability?_____

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 for emergency use only.

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

Last (Family) Name_____ First (Given) Name_____ Birthdate _____
Month/Day/Year

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		Hepatitis		Seizures	
Anemia		Diabetes – Indicate Type		Heat Stroke/Sun Stroke		Sickle Cell Trait/Disease	
Atypical Bleeding/Clotting		Disability – Indicate Type		Hernia		Sinus Trouble	
Anxiety		Ear Trouble/Hearing Loss		High Blood Pressure		Skin Condition	
Asthma		Dislocations/Fractures		High Cholesterol		Sleep Disorder	
Autoimmune Disorder		Disordered Eating		Intestinal/Stomach Disorder		Syncope (Fainting)	
Bladder Infections		Drug/Alcohol Treatment		Kidney Disease/Stones		Thyroid Disease	
Cancer		Eye Trouble/Vision Loss		Mononucleosis		Tobacco Use	
Chest Pain		Fibromyalgia		Orthopedic Problem (Chronic)		Tuberculosis	
Chicken Pox		Gynecological Condition		POTS		Undescended Testicle	
Clotting Disorder		Headaches (Indicate type)		PTSD		**Other:**	
Concussion/Head Injury***		Heart Murmur		Rheumatic Fever			
COVID-19		Heart Condition		Scoliosis			

If you have checked any of the boxes above or have 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**

Physical Examination for Cornell College (*To be completed by MD, DO, NP or PA- needs to be in English)*

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. **This form should be given to the student, who will return it to Health Services.** **NOTE: TB testing and x-rays should NOT be done prior to the student's arrival in the US.**

Patient's Full Name _____

Birthdate _____ Assigned sex at birth: Male Female Gender Identity: Male / Female / _____

BP _____ Pulse_____ Height_____ Weight_____ Vision _____

ALL NCAA 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: THE STUDENT SHOULD NOT HAVE TUBERCULOSIS TESTING OR X-RAYS PRIOR TO ARRIVAL.

Provider's Clinic Stamp Here:

Provider's Signature_____

Date _____

Phone_____

Cornell College

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

CERTIFICATE OF IMMUNIZATION

Name _____

Date of Birth _____

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.	
COVID-19	1.	
	2.	
Typhoid (oral or injectable – please indicate)		
BCG		

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