WESTMINSTER COLLEGE

STUDENT HEALTH FORM

Students will not be allowed to begin classes without the required immunizations and have the records on file in the Wellness Center.

HEALTH HISTORY

Name (Last, First, MI) ____

Home Address ______________________________ Date of Birth (Month/Day/Year) ________________

City, State, Zip______________________________________ Country ____________________

Home Phone (_____) ___________________________ Cell Phone (_____) ___________________________ Sex: M F

Emergency Contact Information

Name ____Relationship ____________________

Address_______________________________________ _______________________________________

Home Phone (_____) __________________ Work Phone (_____) _________________ Cell Phone (_____) __________________

Confidential Medical History

Do you have a past or present history of the following? Check all that apply:

___Chicken Pox
___Mumps
___Frequent Infections/Sore Throat
___Asthma
___Hives/Eczema
___Mononucleosis
___Anemia
___Kidney/Bladder Infection
___Bronchitis—Chronic
___Jaundice
___Heart Disease
___Pneumonia

___Kidney Disease/Stone
___Rheumatic Fever
___History of Blood Clots
___Cancer
___Migraine Headaches
___Diabetes
___Hay Fever
___Ulcers
___Bursitis, Chronic Back Pain
___Gout
___Arthritis
___Polio/Meningitis

___High Blood Pressure
___Measles
___Epilepsy
___Sexually Transmitted Infection
___Malaria
___Tuberculosis
___Injuries:
Legs/Feet___________
Head/Neck__________
Back/Chest__________
Pelvis______________

Brief explanation of any marked above ____

____

Mobility difficulties, hearing loss, sight impairment (circle all that apply). Explain______________________

Current medications____

Drug allergies and reaction____

____

Other allergies (animals, seasonal, food, etc.) ______________________________________

Hospitalizations and/or surgeries ____

If you have any of these concerns:

Substance Abuse	past	current	Eating Disorder	past	current
Depression	past	current	Anxiety/Panic Attacks	past	current
Aspergers	yes		Attention Deficit Disorder	past	current
Recent loss of loved one	yes		Other ______________________		

Give relevant details to any concern marked above, including any medications taken during the past 4 years __________________

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IMMUNIZATION RECORD

REQUIRED FOR ALL STUDENTS:

- **Copy of Complete Immunization Records** (attach to form)

REQUIRED FOR ALL STUDENTS:

- **MMR (Measles, Mumps, Rubella) Two Doses** **Date - dose #1** ___________________________
  Documentation required prior to attending class
  Date - dose #2___________________________
- **Tdap Booster** (Tetanus, Diphtheria, Pertussis)
  One time booster dose **Date - booster** ___________________________

RECOMMENDED FOR ALL STUDENTS:

- **Meningococcal vaccine** (Meningitis)
- **Varicella** (two doses; commonly known as "Chicken Pox")
  No vaccine is needed if there is a good history of natural infection.
- **Hepatitis B series** (three doses)

REQUIRED FOR ALL INTERNATIONAL STUDENTS AND STUDENTS WHO ARE AT HIGH RISK OR WHO HAVE TRAVELED ABROAD:

- **Tuberculin Test** (no exemption allowed) **Do not have this test done prior to arrival on campus!** The Tuberculin Test will be completed, on campus, in The Wellness Center.

REQUIRED HEALTH INSURANCE

Westminster College has joined a growing number of the nation's institutions of higher education in requiring health insurance as a condition of enrollment for all full-time students.

- **STUDENTS WHO ARE US CITIZENS and have health insurance coverage through parents or elsewhere will not be required to buy the College-sponsored plan, BUT MUST OPT OUT ONLINE EACH YEAR.**

  YOU WILL BE BILLED AUTOMATICALLY
  ***FOR THE INSURANCE PREMIUM unless* YOU OPT OUT!**

  To opt out, the student needs to complete the online form at http://www.westminster-mo.edu/optout prior to the opt-out deadline, August 30th for fall enrollment and January 30th for spring enrollment.

  The opt-out waiver must be completed once each school year.

  Parents are encouraged to review insurance issues with their student before arrival on campus and to see that the student is given a copy of the insurance card to carry at all times. Should a student need care beyond the scope of the on-site clinic, such as x-rays, lab work or pharmaceuticals, the student will be responsible for the bill. For this reason, it would be in the student's best interest to have a list of preferred local providers if the coverage extends to the mid-Missouri region.

- **INTERNATIONAL STUDENTS are required to enroll in the College-sponsored health insurance plan (no exceptions).**

PRIVACY STATEMENT

I understand that The Wellness Center at Westminster College may need to use and disclose information about my health or medical problems for the purposes of arranging, conducting, or referring my treatment; for obtaining payment for services; and for operating the practice. I consent to the use of my information for the purposes of treatment, payment and health care operations. I understand that my consent is not needed when the law requires The Wellness Center at Westminster College to report some aspect of my protected health information to a government agency (for example, suspected abuse, communicable disease, and potential for serious bodily harm to myself or others). I understand that I have the right to review The Wellness Center's privacy notice, to request restrictions on the use of my information, and to revoke my consent at a later date.

I understand that if I withhold consent for the use of my information for the purposes of treatment, payment, or operations, The Wellness Center may refuse to undertake my care.

Student's Printed Name ____

Student's Signature______________________________________ **Date**__________________

Students under 18:

Parent/Guardian Signature ______________________________ **Date** __________________

CONSENT FOR TREATMENT

All Students:

By my signature, I verify that the information provided on this form is true, and I give permission for such diagnosis, tests and therapeutic procedures, as may be deemed necessary for me.

Student's Printed Name ____

Student's Signature______________________________________ **Date**__________________

Students under 18:

I grant permission to the medical staff at The Wellness Center, Westminster College, to treat my son/daughter as may be necessary and, if needed, to refer to private care when special service is indicated.

Parent/Guardian Signature ______________________________ **Date** __________________

RETURN COMPLETED FORM TO:

501 Westminster Ave.
Fulton, MO 65251-1299
Phone: 573-592-5361
Fax: 573-592-5180