

Confidential Sharing Agreement and Consent For Treatment

The college assures that medical information will be regarded as confidential and shared only as necessary for the student's immediate safety. Health Service will not release medical information to parents unless the student signs a separate release of information specific to each illness/incident.

If a serious illness or accident should occur, and there is concern for the student's safety, every effort will be made to contact parents or guardian. However, in the event that delay in medical or surgical treatment may be detrimental to the health of the student, authorization for consultation and treatment by area physicians is requested. Luther College Health Service recognizes the importance of cooperating with the student's family physician, clinic, or hospital in providing health care while the student is enrolled in college. In order to secure or exchange health information, it is necessary to have the permission of the student or parent/guardian if the student is under 18. On occasion, information regarding physical or mental health status of a student may be shared with the vice president for student life or counseling staff if there is a concern for the student's immediate safety or the safety of others. No information will be provided to faculty or work study supervisors without specific consent of the student. Due to new federal regulations regarding confidentiality, additional consents regarding health information will need to be signed at the time the student is seen in Health Service.

Permission is hereby granted to share health information with my family physician, clinic, hospital, vice president for student life, or counseling staff if there is a concern for my immediate safety or the safety of others.

Signature of student

Date

Signature of parent/guardian (only needed if student is under age 18)

Date

HEALTH INSURANCE

All students are enrolled in the supplemental insurance plan—information will be mailed by July. If your family policy coverage is adequate, you may waive the premium by completing the **online** waiver (which will be open July 1 through September 1). Completing the following information does **not** fulfill your obligation to do the online waiver. We also suggest that students carry a current insurance card with them. More information can be found on the health service website, www.luther.edu/student-life/health-service/.

Policy Holder Name

Policy Holder Birthdate

Policy Holder Address

City

State

ZIP

Policy Holder Employer

Policy Holder mother father self other _____

ATTACH A COPY of the front and back of your insurance card.

*Please attach a copy of the front
of your insurance card here.*

*Please attach a copy of the back
of your insurance card here.*

Immunizations

Last Name _____

First Name _____

Luther College ID # _____

NOTICE: The remainder of this Student Health Evaluation Form requires an appointment with your health care provider. If your health care provider does not have a complete immunization record and you attended school in the United States, you can obtain the records from your school.

TO THE HEALTH CARE PROVIDER: Measles, Mumps, and Rubella—Two doses required of all students born after December 31, 1956. With dose #1 given at age 12 months or later. Dose #2 given at least 28 days after first dose. Lab titers can be done for Rubeola if immunity is questioned.

REQUIRED IMMUNIZATIONS

		month/day/year
DTP <i>(Primary Series Dates)</i>	#1	
	#2	
	#3	
	#4	
Td or Tdap	#5	

		month/day/year
POLIO <i>3 dose primary series and booster</i>	#1	
	#2	
	#3	
	#4	

		month/day/year
MMR <i>(Measles, Mumps, Rubella) 2 doses required</i>	#1	
	#2	

		month/day/year
TD or DTAP <i>(Within 10 yrs) Tetanus/Diphtheria or Diphtheria/Tetanus/Pertussis</i>	#1	
	#2	

REQUIRED TB SCREENING for INTERNATIONAL STUDENTS ONLY

The Mantoux test must be done in Iowa. This test (\$10) can be done at Luther College Health Service. **Do NOT have a BCG vaccination prior to your departure.**

Tuberculosis Screening (PPD required regardless of prior BCG inoculation)

1. PPD (Mantoux) within the past 12 months (tine or monovac not acceptable).

Date given: _____ Date read: _____ Results: _____ mm

PPD must be read by a health care professional 48-72 hours following the test. Read and record in millimeters of induration ONLY, rather than redness.

2. If TB skin test is read as positive, chest x-ray is required.

X-ray result: Normal Abnormal _____ / _____
month / year

Treatment with medication may be recommended for 9 months if screening is positive.

Additional Tuberculosis Screenings

date given _____; date read _____, results: _____ mm

date given _____; date read _____, results: _____ mm

date given _____; date read _____, results: _____ mm

CONSCIENTIOUS/RELIGIOUS EXEMPTION

MUST BE NOTARIZED.

Must fill out if unable to meet required immunizations due to conscientious or religious belief.

I hereby certify by notarization that my conscientious or religious belief is opposed to immunizations.

Student Signature (or parent or legal guardian if under 18 years of age)

Subscribed and sworn to me on the _____
day of _____, 20____.

Signature of Notary

MEDICAL EXEMPTION

Must be completed if unable to meet required immunizations due to medical contraindications.

The physical condition of the aboved named person is such that immunization would endanger life or health, or is medically contraindicated due to other medical conditions.

Signature of Medical Professional
Date

RECOMMENDED IMMUNIZATIONS

		month/day/year	site	manufacturer	lot #	initials	comments/reactions
MENINGOCOCCAL*							
HEPATITIS B <i>(indicate if twinrix)</i>	#1						
	#2						
	#3						
HEPATITIS A	#1						
	#2						
VARICELLA <i>Chicken Pox: Indicate history of or two doses of vaccine.</i>	#1						
	#2						
INFLUENZA	#1						
	#2						
OTHER							

MENINGOCOCCAL VACCINATION*

Meningococcal disease is a potentially life-threatening bacterial infection caused by Neisseria meningitidis, a leading cause of bacterial meningitis in older children and young adults in the United States. The disease most commonly is expressed as either meningococcal meningitis, an inflammation of the membranes surrounding the brain and spinal cord, or meningococemia, a serious infection of the blood.

Since 1991, cases of meningococcal disease among 15 to 24 year olds have increased. Studies show that students residing in on-campus dormitories, especially first-year students, appear to be at up to a six-fold increase risk for meningococcal disease than college students overall.

Vaccination: Two vaccinations are available against four of the most common strains of N. meningitidis in the United States, (A, C, Y, W-135). The vaccines are

85-100 percent effective in preventing disease in older children and adults. Studies suggest that up to 80 percent of college cases are vaccine preventable.

For additional information go to www.luther.edu/student-life/health-service/immunizations/meningitis/.

- I have received the meningococcal vaccine. See above.
 I decline the vaccination.

I have read the above information on meningococcal disease, recommendations, and vaccination.

Signature of Student

Date

Physical Examination by Health Care Provider

MUST BE COMPLETED WITHIN 12 MONTHS PRIOR TO COLLEGE ENTRANCE

Student Name _____ Birthdate _____ Today's Date _____

Height _____ Weight _____ Temp. _____ Pulse _____ Resp. _____ BP _____

EXAMINATION	Normal	Abnormal	Abnormal Findings (numbered and noted)
	<small>(no mark = not examined)</small>		
1. General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Head / Face	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Ears	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Nose & Sinuses	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Mouth / Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Neck	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Thorax	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Breasts	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	_____
15. Rectal	<input type="checkbox"/>	<input type="checkbox"/>	_____
16. Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
17. Lymphatics	<input type="checkbox"/>	<input type="checkbox"/>	_____
18. Blood Vessels	<input type="checkbox"/>	<input type="checkbox"/>	_____
19. Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
20. Psychological	<input type="checkbox"/>	<input type="checkbox"/>	_____
21. Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
22. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____
23. Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
			OPTIONAL
			24. Vision Screening _____ 26. Cholesterol _____
			25. Hgb/Hct _____ 27. Urinalysis _____

I find no medical reason to disqualify _____ from participation in athletics.
Student's Name

If disqualified, please explain: _____

Recommendations for treatment, restriction of academic load, or physical activity. Please include period of time for restriction and comments on history.

Are you this student's usual provider? Yes _____ No _____

Health Care Provider's Signature _____ Date _____

Health Care Provider's Name (printed) _____

Street Address _____ City _____ State _____ ZIP _____

Phone number _____ FAX number _____

Students: Upon completion of your forms, mail to Health Service, Luther College, 700 College Drive, Decorah, IA 52101.