UNIVERSITY OF EVANSVILLE

EST 1854

University of Evansville Student Health Center

Fall Semester Deadline		Spring Semester Deadline
July 1	***Instructions-Read prior to completing this form***	December 1

1. **University of Evansville Student—** All full-time undergraduate and graduate students are required to complete Parts I, II, III, IV and V. If under 18 years of age, also complete Part IV and V with your parent/guardian.
2. **Proof of Immunization—**Provide proof of immunization by submitting one of the following:
   - Part II Required Immunizations (page 2) must be completed, signed and dated by a health care professional

     OR
   - Submit a copy of your immunization records from your physician, former high school or university, or other official immunization records. Any paperwork submitted must list all required immunizations.
3. **No Immunization Record—**If you have no immunization records, you have the option to complete blood tests to prove immunity or be re-vaccinated.
4. **Penalty—**Students who fail to submit the completed Student Health Form, including proof of immunizations, or fail to rectify deficiencies within 30 days after the start of the semester will:
   - Not be allowed to physically attend classes and be held from class registration for subsequent terms until compliant in accordance with the state of Indiana and University policy.
5. **Completed Forms—**Mail to University of Evansville Health Center, 1800 Lincoln Ave., Sampson Hall, Evansville, IN 47722
6. **Communication—** The student's university email address will be used to communicate regarding compliance issues.

Part I: STUDENT AND ACADEMIC INFORMATION

Today's Date (mm/dd/yyyy) _____ UE Student ID # _____

Last name or Family name _____ First name _____ Middle _____ Male or Female

Permanent Address _____ Date of Birth (mm/dd/yyyy) _____

Local Address _____ Cell Phone Number (with area code) _____

Emergency Contact– Name _____ Relationship to student _____ Phone Number of Contact _____

First term attending and year of enrollment: Fall 20_____ Winter 20_____ Spring 20_____ Summer 20_____

I will be enrolled:____Part-Time_____Full-Time Are you a NCAA athlete?____Yes_____No Living on Campus? Yes No

HEALTH INSURANCE INFORMATION:

The University of Evansville highly recommends that all full-time students carry health insurance. The student may rely on his or her own insurance or his or her family's personal insurance policy. It is the student's responsibility to ensure all health insurance information on WebAdvisor is up to date so if there is an emergency, the University will be able to provide this information to a health care provider.

**Please note: International students on F-1 and J-1 visas will be automatically enrolled in a health insurance plan unless they can provide proof of qualifying insurance from their home country or through a government sponsored plan.*

Insurance Company: Name _____ Mailing Address of Ins. Co. _____ Phone Number of Ins. Co. _____

Policy Holder's Name _____ Date of Birth of Policy Holder _____ Policy Number _____ Group Number _____

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PART II: REQUIRED IMMUNIZATIONS

FULL-TIME STUDENTS

All full-time students are required by the University of Evansville and the State of Indiana to submit proof of immunizations. **THIS PAGE MUST BE COMPLETED BY A HEALTHCARE PROVIDER (e.g. MD, DO, PA or RN)**; and include their name (printed), phone number, signature and date at the bottom to be considered valid under Indiana State Law. Dates of vaccinations are required.

OR

Submit a copy of your immunization records from your physician, former high school or university, or other official immunization records. Any paperwork must list all **required** immunizations.

Student Name:_____ **UE Student ID #:**_____ **Date of Birth:** _____

M-M-R (COMBINED Measles, Mumps, Rubella)

Vaccination (**2** doses required).

- **If given separately, complete section below instead.**

CDC/ACIP recommends 2 doses of MMR.

Date of Dose #1 (on or after 1st birthday ***AND*** after /1/1968):

____/____/____(mm/dd/yyyy)

Date of Dose #2 (at least 28 days after dose #1):

____/____/____(mm/dd/yyyy)

MEASLES (Rubeola)

2 doses required. Both must be done on or after 1st birthday, after 1/1/1968, and at least 28 days apart.

Date #1 :____/_____/ _____

Date #2 :____/_____/_____ **OR—**

Date of Illness:_____/_____/_____

OR— Attach copy of lab report (titer) confirming immunity (antibodies).

MUMPS

1 dose required on or after 1st birthday.

Date:_____/_____/ ____

OR— Date of Illness:_____/_____/ ____

OR—Attach a copy of lab report (titer) confirming immunity (antibodies).

RUBELLA (German Measles)

2 doses required. Both must be done on or after 1st birthday, after 1/1/1968, and at least 28 days apart. *

Date #1:____/____/ ____

Date #2:____/____/ ____

OR—Attach copy of lab report (titer) confirming immunity (antibodies).

*Date of illness not accepted for Rubella.

TETANUS/DIPHTHERIA BOOSTER (Td or Tdap fulfill the requirement)

- Must be within 10 years prior to beginning at the University of Evansville.
- CDC/ACIP recommends Tdap if not received since 2006.

Date:_____/_____/ _____

Please circle which given:
Td Tdap

TUBERCULOSIS— TB skin test *given and read* in the United States within the last six months

Date Administered:_____/_____/ _____

Date Read:_____/_____/ _____

Results:_____(millimeters) Name/Title_____

MENNINGOCOCCAL— Date:_____/_____/ ____

OPTIONAL NOT REQUIRED

VARICELLA (Chicken Pox) - Date:_____/_____/_____Date #2:_____/_____/_____Date of Illness:_____/_____/ ____

HEPATITIS B - Date #1:_____/_____/_____Date #2:_____/_____/_____Date #3:____/_____/ ____

HEPATITIS A— Date #1:_____/_____/_____Date #2:_____/_____/ ____

HPV (Human Papillomavirus) - Date #1:_____/_____/_____Date #2:_____/_____/_____Date #3:_____/_____/ ____

HEALTHCARE PROVIDER: By signing below, you attest that all information supplied in this section is true and correct to the best of your knowledge.

Name and title of Provider_____ Signature of Provider_____

Date_____ Phone Number _____

Exemptions: If you feel you are exempt from vaccination requirements based on medical contraindication, religious beliefs or pregnancy, please contact the University of Evansville Health Center at 812-488-2033 to discuss the necessary procedures and documentations.

UNIVERSITY OF EVANSVILLE –**Part III: HEALTH HISTORY**

Student Name:_____ **UE Student ID #:**_____ **Date of Birth:** _____

Personal Health History

PLEASE CHECK YES OR NO (Y/N), PROVIDING SPECIFIC DETAILS TO ALL "YES" ITEMS TO THE BEST OF YOUR KNOWLEDGE.

Y	N	ITEM	DETAILS
		Will you be receiving allergy shots at UE?	Please refer to the UE Health Center allergy injection policy .
		Do you have a history of allergies?	List allergies:
		Do you take medication on a regular basis? (prescription and over-the-counter)	List name of medication, dose and frequency: (ex: Ibuprofen 200mg 2 tablets 2 times daily.)

PERSONAL HEALTH HISTORY

ITEM	Y	N	YEAR	CHECK EACH ITEM	Y	N	YEAR
Alcohol or drug problem				Epilepsy/Seizure Disorder			
Smoking history				Kidney disease or dialysis			
Asthma				Heart Condition, disease, or murmur			
Attention Deficit/Hyperactivity Disorder				Sleep Disorder			
Cancer, leukemia or lymphoma				High Blood Pressure			
Thyroid disorder				Migraine Headaches			
Cholesterol or lipid problems				Mononucleosis/Epstein-Barr virus			
Concussion/Mild Traumatic Brain Injury				Stomach disorders or digestive issues			
Depression or Anxiety (specify)				Anemia or blood disorders			
Diabetes Mellitus				Tonsillectomy			
Eating Disorder/Anorexia/Bulimia				Appendectomy			
Emotional/Psychological problems				Skin disorders			

VITALS Height_____ft.._____in. Weight_____lbs. Blood Pressure:_____/_____ Pulse _____

PHYSICAL EXAMINATION

	Normal	Abnormal		Normal	Abnormal
Eyes			Hernia		
Ears			Orthopedic implant		
Nose			Posture		
Throat			Nutrition		
Lymph Nodes			Nervous history		
Heart			Menstrual history		
Lungs			Anorectal		
Abdomen			External genitals		

HEALTHCARE PROVIDER: By signing below, you attest that all information supplied in this section is true and correct to the best of your knowledge.

Name and title of Provider_____ Signature of Provider_____

Date_____ Phone Number _____

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PART IV: STUDENT SIGNATURE (REQUIRED)

STUDENT SIGNATURE (REQUIRED)

PERMISSION FOR TREATMENT: I consent to treatment from the University of Evansville Health Center and agree to release information on this form, including contents, to the appropriate University officials.

Student's Signature | Parent/guardian's Signature (if student is under 18 years of age) | Date

PART V: TREATMENT/SHARING OF MEDICAL INFORMATION OF MINORS

TREATMENT/SHARING OF MEDICAL INFORMATION OF MINORS

As the parent/guardian of my minor (under 18 years of age) son or daughter, in pursuant to Indiana Code 16-36-1-6 and subject to any limitations listed below, I request and authorize:

1) The sharing/exchange of relevant medical information between University of Evansville Student Health Center representatives for the purpose of diagnosis and/or treatment with other medical providers. Each of the above individuals or entities is also authorized to communicate and discuss health matters with the parents/ guardians/emergency contacts of my minor child.
2) The transportation of my minor child, under appropriate circumstances, to area hospitals for diagnosis and treatment.
3) The provision, by the University of Evansville Student Health Center, of such diagnostic, therapeutic, voluntary immunization, and minor procedures as may be deemed necessary for my minor child. In my absence, my child may sign on their behalf for treatment and method of payment for each visit rendered at the Student Health Center.

Parent/guardian Signature:_____ Relationship:_____ Date:_____

Student's Signature:_____ Date: _____

In addition, I give permission for the following individuals to receive Protected Health Information of my minor child:

Name	Relationship	Phone Number w/ area code

With my signature above, I acknowledge and understand that this Authorization will be kept as part of the medical record, for me or the patient listed whom I am legally responsible for, and that the communication instructions listed above will remain in effect until revoked or changed by me in writing.