

Name	
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Upper Iowa University

STUDENT REPORT OF MEDICAL HISTORY

To the student: The primary purpose of this form is to assure that immunizations are current and that entering students pose no public health problem. Information supplied will become part of your student record, will be held in strict confidence, and will not influence your standing at Upper Iowa. All entering new students and transfer students are required to complete the Student Report of Medical History before enrolling for classes.

Please complete this form carefully. You must fill in the Record of Medical History section and your physician can assist you in completing the Immunization Record. Students may also submit a copy of their own immunization records, in lieu of the enclosed form.

To the student athlete: Prior to participating in athletics at Upper Iowa University, all student-athletes must complete and return the following forms. Assumption of Risk/Emergency Medical Authorization, Insurance Policy Information, Annual Medical History Questionnaire, Returners Medical History Questionnaire (returning athletes only) and Physical Form. The required forms are available in two formats for downloading at: <http://www.upperiowaathletics.com/athletic-training/sa-forms.html>

Completed student-athletic forms should be mailed to the Athletic Training Office.

Student Accident & Health Insurance Requirement. Upper Iowa University is vitally interested in making your academic and personal experience meaningful and successful. Your health and wellness are key components of that experience. The University and the students have a mutual investment that should be protected. To ensure that students get the care they need to stay in class and avoid the potential hardship of medical expenses, we require all full-time and/or resident students to have adequate health and accident coverage. Students have the option of maintaining primary coverage under a family employee plan or private insurer, or must enroll in the school-sponsored plan, serviced and written by **Student Assurance Services, Inc.**

This is a quality, low-cost plan with the following features:

- Local providers referred by Upper Iowa University have no network restrictions
- Plan benefits serve as primary coverage, or provide excellent excess or “gap” coverage
- Worldwide access and emergency travel assistance for study or travel abroad
- Ask Mayo Clinic provides telephone access to registered nurses.
- Dependent coverage available

All full-time traditional, undergraduate students will be enrolled in the Accident and Sickness Insurance Plan. The charge will be posted to your student account and is payable with your tuition bill, unless you wish to waive the annual cost by demonstrating proof of comparable coverage. You must go on-line to waive this coverage. The full plan brochure and waiver instructions are available on-line at www.sas-mn.com. (click on College Student, choose the state of Iowa and then Upper Iowa University from the dropdown menus). Please consider your coverage options carefully. While a parent’s employee plan may provide adequate benefits close to home, HMO and PPO restrictions may limit coverage for students out of state or you local area. The Student Assurance Services plan can cover these gaps in an employer plan as well as the cost of high plan deductibles. Questions? Please contact Student Development.

Student Report of Medical History

Upper Iowa University

All entering new students and transfer students are required to complete the Student Report of Medical History before enrolling for classes. Please complete this form carefully.

1) Authorization for treatment

The parent/guardian and/or student hereby authorize(s) qualified personnel to give examinations, treatments, immunizations and other medical care necessary while the above-named student is attending Upper Iowa University. It is understood that in the case of serious illness or accident, the family of the student will be notified. However, should it be impossible to reach the parent/guardian, and an emergency operation and/or other emergency procedures is/are deemed necessary for the above-named student, it is understood further that the family hereby empowers the authorities of Upper Iowa University to authorize said operation or procedure. Medical providers are authorized to provide medical records, information or opinions to Upper Iowa University upon request.

Signature of parent/guardian _____ Date _____

Signature of student _____ Date _____

2) Legal Consent

Upper Iowa University Health Service aims to cooperate with the family physician, hospital or clinic in the care of the student's health while enrolled. Sometimes it is necessary for the university to release information contained in this form to appropriate college officials and/or health care professionals, including ambulance services, medical clinics, hospitals and physicians. In order to secure or exchange such information, it is necessary to have the written permission of the student and the parent of guardian if the student is a minor. The college assures that this information will be regarded as confidential and used only for the student's welfare. The signature below grants such information.

Signature of parent/guardian _____ Date _____

Signature of student _____ Date _____

3) Name _____ (_____) _____
Last First Middle Mobile Phone

Home address _____
Mailing Address City or town State Zip

Social security number _____ Sex ___F ___M Birthdate _____
Month/Date/Year

Entering term, please list year: Fall _____ Spring _____ (Term 1 _____ Term 2 _____ Interim _____)
Year Year

4) Person to notify in case of emergency

Name _____ Relationship to student _____

Address _____

Home phone (_____) _____ Work phone (_____) _____ Mobile phone (_____) _____

Email Address: _____

5) Parent/Guardian Information

Father/Guardian: _____ Mother/Guardian: _____

Address _____ Address _____

City, ST _____ City, ST _____

Employer _____ Employer _____

Telephone (_____) _____ Telephone (_____) _____

6) Health Insurance Information

Medical insurance company or plan _____

Address _____

Policy number _____ Group number _____

Policy holder _____ Relationship to student _____

Telephone (_____) _____

Is the company or plan listed above considered a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO): ____ Yes ____ No

Does your insurance or plan require a second opinion before surgery? ____ Yes ____ No

____ **I am not covered by a health insurance policy.** See Student Accident & Health Requirement located on the first page.

7) Personal medical history

Please place a check (✓) next to any of the medical problems that have affected your health. Double check (✓✓) those that have occurred within the last year.

- | | | |
|---|--|---|
| <input type="checkbox"/> a. Infectious mononucleosis | <input type="checkbox"/> j. Menstrual problems | <input type="checkbox"/> r. Back injury, or chronic back pain |
| <input type="checkbox"/> b. Frequent sore throat or strep | <input type="checkbox"/> k. Seizure disorders | <input type="checkbox"/> s. Hernia |
| <input type="checkbox"/> c. Frequent head colds | <input type="checkbox"/> l. Fainting spells | <input type="checkbox"/> t. Hepatitis |
| <input type="checkbox"/> d. Sinus trouble | <input type="checkbox"/> m. Diabetes | <input type="checkbox"/> u. Heart trouble |
| <input type="checkbox"/> e. High blood pressure | <input type="checkbox"/> n. Rheumatic fever | <input type="checkbox"/> v. Heart murmur |
| <input type="checkbox"/> f. Frequent headaches or migraines | <input type="checkbox"/> o. Head injury with unconsciousness | <input type="checkbox"/> w. Anemia |
| <input type="checkbox"/> g. Hay fever | <input type="checkbox"/> p. Joint disease/injury | <input type="checkbox"/> x. Shortness of breath |
| <input type="checkbox"/> h. Asthma | <input type="checkbox"/> q. Shoulder dislocation, "trick" knee | <input type="checkbox"/> y. Kidney disease |
| <input type="checkbox"/> i. Allergies | | <input type="checkbox"/> z. Alcohol or drug abuse |

State any surgical operations or hospitalization you have had and indicate dates _____

8) Medical problems

- a. Do you have a disability or any other medical or physical problem that restricts your activity? ____ yes ____ no
- b. Are you currently under the care of a physician? ____ yes ____ no
- c. Are you currently taking any medications? ____ yes ____ no
- d. Are you allergic to any medications? ____ yes ____ no
- e. Do you have any dietary restrictions? ____ yes ____ no
- f. Do you have any special housing needs, recommendations or restrictions? ____ yes ____ no

If you answered "yes" to any of the above questions, please specify below:

Comments _____

9) Are you currently under treatment for any of the following conditions?

- a. Eating disorder ___yes ___no If yes, please attach special dietary requirements from attending physician.
- b. Substance abuse ___yes ___no
- c. Other psychological concerns ___yes ___no

10) Do you plan to participate in the UIU athletic program? ___ yes ___ no

If "yes," please indicate what sport(s) _____

To the best of my knowledge, this is an accurate report of my health history.

Signature of student _____ Date _____

Please mail this form along with your Immunization Record to:
Office of Student Development
Upper Iowa University
PO Box 1857
Fayette, IA 52142

Questions? Call Student Development at (563) 425-5215