

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 should fill in the Immunization Record.

1) **Name** _____ (_____) _____
Last First Middle 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 _____ (Term 1____ Term 2____)
Year
Spring _____ (Term 1____ Term 2____) Interim _____
Year Year

2) Person to notify in case of emergency

Name _____ Relationship to student _____
Address _____
Home phone (_____) _____ Work phone (_____) _____ Mobile phone (_____) _____

3) Parent/Guardian Information

Father/Guardian: _____	Mother/Guardian: _____
Address _____	Address _____
Employer _____	Employer _____
City, ST _____	City, ST _____
Telephone (_____) _____	Telephone (_____) _____

4) 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.

5) 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 _____

6) 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. Selected information regarding a student may be helpful to appropriate college officials. In order to secure or exchange such information, it is necessary to have the written permission of the student and the parent or 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 permission.

Signature of parent/guardian _____ Date _____

Signature of student _____ Date _____

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 to:
Office of Student Development
Upper Iowa University
PO Box 1857
Fayette, IA 52142*

Questions? Call (563) 425-5215

Prior to your arrival on campus, you are to have your health care provider furnish the requested information on your immunization records. Students participating in intercollegiate athletics are required to complete a Physician's Report. Please take this form, which includes the Immunization Record, to your health care provider for completion.