



Stone Health Center

Dear New Student,

Welcome to Hastings College from the Health Center staff! We are here to help answer any questions you might have about health-related concerns or problems. You will find important forms to return to the Health Center which will allow us to give you the best of health care while you are a student at Hastings College. Hastings College Campus Health Center services are provided at no extra cost to students, with the exception of immunizations, which are provided at cost. We refer to off-campus healthcare providers for services beyond the scope of practice for Registered Nurses.

ALL STUDENTS: (Including student athletes—the athletic department has *additional* requirements for their records)

- The information on your health record is confidential. For this reason, we urge you to list all pertinent health information so we can give you the very best care **for both acute and chronic conditions.**
- **Complete the attached “Student Information Form: Hastings College Health Center”.**
- **Complete the attached “Hastings College Health Center Treatment Authorization”** including healthcare insurance information and usual health care provider information. **Please include a photocopy of your Health Insurance card (both front and back).** **PLEASE NOTE: The completed form is required for you to be seen/treated at the Stone Health Center.**
- Take the attached **“Hastings College Health Center Immunization Record”** to your healthcare provider for completion. Note that vaccines in sections **“A” through “D” are required** and the vaccines in sections **“E” through “J” are strongly suggested.** For section **“K”** no testing is required if your healthcare provider determines you have no signs or symptoms and are not a member of a high-risk group for Tuberculosis. You will have already received all or most of the required immunization, and need only have your healthcare provider fill in the dates and sign the form.
- **Return all the above forms to the Health Center via mail, or bring them to your registration appointment where we can collect them. If you return them by mail, DO NOT enclose any other materials.**

A word about health insurance...Please ask your parents/guardians to check with the insurance carrier **NOW** to determine the procedure to follow if off-campus medical services are needed. Some family insurance plans **do not** cover expenses out of your immediate geographic area, or at the very least, require the patient to notify the carrier of need for medical care. **All students need to carry a copy of their insurance card (front and back), as they will need that for any medical services off-campus.** Hastings College provides all full-time undergraduate students with a second-pay accident benefit of \$1,000.00 for accidents that occur during the 9-month academic year.

Sincerely,

Beth Littrell

Elizabeth (Beth) Littrell RN-BC, MA, LIMHP
Director of Campus Health Services
Hastings College
Phone: 402-461-7372
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Student Information Form

Date _____

Last Name (Please Print) _____ First _____ Middle _____

Nickname (I prefer to be called) _____

Cell Phone Number _____

Date of Birth _____

Home Address _____
Street City State/Zip

Emergency Contact Information:

Parent(s), Legal Guardian(s) or Spouse's full name(s) _____

Parent(s), Legal Guardian(s) or Spouse's address _____
Street City State/Zip

Phone Numbers: Home (_____) _____ Cell (_____) _____

Email address(s) _____

Other emergency contact information _____
Name

Relationship _____ Phone Number (_____) _____

Health History:

Personal History

Tobacco use, inc. smokeless [] _____
Alcohol use, frequency, quantity [] _____
Seatbelts...check if always used [] _____
Exercise...type, frequency [] _____
Special Diet [] _____

Surgical Operations _____ Date _____
_____ Date _____

Injuries (Serious) _____ Date _____
_____ Date _____

Current Medications _____ Dosage _____
_____ Dosage _____
_____ Dosage _____

Allergies _____ Date _____
Food _____ Date _____
_____ Date _____
Drug Sensitivities or Allergies _____ Date _____
_____ Date _____
Other _____ Date _____
_____ Date _____

Previous Illnesses

	√	Date, if known	Type
Anorexia/Bulimia []	_____	_____	_____
Asthma []	_____	_____	_____
Cancer/Type []	_____	_____	_____
Colon Disease []	_____	_____	_____
Diabetes []	_____	_____	_____
Gynecological Problems []	_____	_____	_____
Hay Fever []	_____	_____	_____
Heart Disease/Murmur []	_____	_____	_____
Hepatitis/Type []	_____	_____	_____
High Blood Pressure []	_____	_____	_____
Kidney Diseases/Stones []	_____	_____	_____
Migraines []	_____	_____	_____
Mononucleosis []	_____	_____	_____
Orthopedic/Type []	_____	_____	_____
Phlebitis/Deep Vein Clot []	_____	_____	_____
Pneumonia []	_____	_____	_____
Seizure Disorder/Type []	_____	_____	_____
Sickle Cell Disease/Trait []	_____	_____	_____
Sinusitis []	_____	_____	_____
Skin Trouble/Type []	_____	_____	_____
TB Test, Positive []	_____	_____	_____
Thyroid Disease []	_____	_____	_____
Ulcer []	_____	_____	_____
Other []	_____	_____	_____

Special Additional History (Emotional or Physical): _____



HastingsCollege™

Stone Health Center

TREATMENT AUTHORIZATION

I authorize the Hastings College Health Center to administer medical and first aid services (including immunizations); to perform emergency care and/or to refer treatment to a local physician or medical facility if deemed necessary.

Print Student Name (first, middle initial, last)

Date of Birth

Signature

Date

Are you under the age of 19 years? If so, your parent or guardian MUST sign below:

Parent/Guardian Signature

Date

Relationship to Student

Healthcare Insurance is required of ALL students:

Name of Health Insurance Company

Policy Number

Group Number

PLEASE attach copy of insurance care (front and back). Student should also carry an insurance card.

Please check with your insurer about procedures to follow if off-campus medical; attention is needed, i.e. hospital or clinic care. Specific notes, are appreciated.

Usual Healthcare Provider or Clinic:

Name

Address:

Street

City

State

Zip

Phone Number: (____) _____



Health Center Immunization Record

PART I

Name _____
First Name Middle Name Last Name

Address _____
Street City State Zip

Date of Entry ___/___/___ Date of Birth ___/___/___ Social Security Number ___/___/___-___/___/___-___/___/___/___

Status Part-time ___ Full-time ___ Graduate ___ Undergraduate ___

PART II – TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

All information must be in English.

A. M.M.R. (MEASLES, MUMPS, RUBELLA)

(Two doses required at least 28 days apart for students born after 1956 and all health sciences students.)

1. Dose 1 given at age 12 months or later. #1 ___/___/___
M D Y

2. Dose 2 given at least 28 days after first dose. #2 ___/___/___
M D Y

B. POLIO

(Primary series, doses at least 28 days apart. Three primary series are acceptable. See ACIP website for details.)

1. OPV alone (oral Sabin three doses): #1 ___/___/___ #2 ___/___/___ #3 ___/___/___
M D Y M D Y M D Y

2. IPV/OPV sequential: IPV #1 ___/___/___ IPV #2 ___/___/___ OPV #3 ___/___/___ OPV #4 ___/___/___
M D Y M D Y M D Y M D Y

3. IPV alone (injected Salk four doses): #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___
M D Y M D Y M D Y M D Y

C. VARICELLA

(Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets the requirement.)

1. History of Disease Yes ___ No ___ or Birth in U.S. before 1980 Yes ___ No ___

2. Varicella antibody ___/___/___ Result: Reactive ___ Non-reactive ___
M D Y

3. Immunization

a. Dose #1.....#1 ___/___/___
M D Y

b. Dose #2 given at least 12 weeks after first dose ages 1-12 years and
at least 4 weeks after first dose if age 13 years or older Dose #2 ___/___/___
M D Y

(continued)

K. TUBERCULOSIS (TB) SCREENING/TESTING ¹

The American College Health Association has published guidelines on “Tuberculosis Screening and Targeted Testing of College and University Students.” To obtain the guidelines, visit www.acha.org.

Please answer the following questions:

1...Does the student have signs or symptoms of active tuberculosis disease? Yes _____ No _____

If No, proceed to #2. If Yes, Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Is the student a member of a high-risk group or is the student entering the health profession?² Yes _____ No _____

If ‘No’, stop. If yes, place tuberculin skin test (Mantoux only: inject 0.1ml of purified protein derivative [PPD] tuberculin containing 5 tuberculin units [TUI] intradermally into the volar [[inner] surface of the forearm.) A history of BCG vaccination should preclude testing of a member of a high-risk group.

3. Tuberculin Skin Test: Date Given: _____/_____/_____ Date Read: _____/_____/_____
M D Y M D Y

Result: _____ (Record actual mm of induration, transverse diameter if no induration, write “0”)

Interpretation (based on mm of induration as well as risk factors): Positive _____ Negative _____

4. Chest x-ray (required if tuberculosis skin test is positive) result: Normal _____ Abnormal _____

Date of chest x-ray: _____/_____/_____
M D Y

HEALTH CARE PROVIDER

Name _____ Address _____

Signature _____ Phone (_____) _____

¹The American College Health Association has published guidelines on tuberculosis screening of college and university students. These guidelines are based on recommendations from the Centers for Disease Control and the American Thoracic Society. For more information, visit www.acha.org or refer to the CDC’s Core Curriculum on Tuberculosis available at state health departments or at the follow website: www.cdc.gov/nchstp/tb/pubx/corecurr/.

²Categories of high risk students include those students who have arrived within the past 5 years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia or New Zealand. Other categories of high-risk students include those with HIV infections, who inject drugs, who have resided in, volunteered in or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias, or lymphoma, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone 15mg/d for 1 month) or other immunosuppressive disorders.