LORAS COLLEGE
HEALTH CENTER

For office use only:
Registration Date: _____
☐Fall semester 20_____
☐Spring semester 20_____

COMPLETE FRONT AND BACK

RETURN TO: Health Center
Loras College Mail #160
P.O. Box 178
Dubuque, IA 52004-0178

Phone: (563) 588-7142
Fax: (563) 588-7659

Please Print or Type. **Please complete in English.**

LORAS I.D. # (if available) _____ BIRTH DATE: ___/___/_____ (mo. / day / year) CELL PH. #: (_____)_____

NAME: _____
Last First Middle

HOME ADDRESS: _____
Street City State/Country Zip

FATHER'S NAME: _____
Last First

FATHER'S PHONE: Home _____ Work _____ Cell _____

MOTHER'S NAME: _____
Last First

MOTHER'S PHONE: Home _____ Work _____ Cell _____

SEX: ___ Male ___ Female INTERNATIONAL STUDENT: ___ Yes ___ No

PERSON TO NOTIFY IN EMERGENCY *OTHER THAN PARENT(S)*: _____

_____ (_____)_____ (_____)_____ (_____)_____
Relationship Home Phone Work Phone Cell Phone

HEALTH INSURANCE COMPANY: _____

POLICY NUMBER: _____/Gr.#_____

POLICY NAME: _____ BIRTH DATE OF HOLDER: M_____ D _____ Y _____

CUSTOMER SERVICE PHONE NUMBER: _____

STUDENT SHOULD CARRY A COPY OF THE INSURANCE CARD—*VERY IMPORTANT INFORMATION* in an emergency!

Provide a list of Physicians in Dubuque that your insurance has approved for medical services:

_____

_____

_____

Privacy of confidential information is a social, legal, and ethical responsibility of organizations that receive medical information. The Loras College Health Center has a policy to protect the confidentiality of patient data, whether it is electronic or printed information.

All patient records maintained by the Health Center are private. Only authorized Health Center personnel may release patient records, and then, only with written authorization from the patient. Parents of patients eighteen years and older, parents or spouses of emancipated minors, and other next of kin will not have access to the medical record without the written consent of the patient.

Rev.: 11/06; 3/08; 12/08

Personal Health History

1. REQUIRED IMMUNIZATIONS – *MUST BE COMPLETED.*

If born after 1957:

TWO MMR injections that have been given after the first birthday, at least one month apart.

(1st) Month/day/year : _____/_____/_____ **(2nd) Month/day/year :** _____/_____/_____

OR attach a laboratory copy showing immune **Rubeola, Rubella and Mumps IgG titers.**

_____

➡ **REQUIRED: Signature and office stamp of physician or immunizing official OR** attach **official copy** of immunization record.

2. REQUIRED FOR INTERNATIONAL STUDENTS ONLY: QuantiFERON Gold TB test completed in the United States in the past year. Please attach copy of lab results.

3. Other Immunizations

List dates of injection by: M/D/Y

1. Rubeola: _____
2. Mumps: _____
3. Rubella: _____
4. Tetanus (Td): _____ Tdap: _____
5. Polio: _____
6. Hepatitis B: 1. _____ 2. _____ 3. _____
7. HPV: 1. _____ 2. _____ 3. _____
8. Chicken Pox (Varicella): _____
9. Other: _____

_____

***4. Meningitis–Menomune or Menactra:**

_____

5. I HAVE THIS "MED-ALERT" CONDITION:

_____

6. Allergies

Please check those to which you are allergic.

- ☐ NONE
- ☐ Aspirin
- ☐ Codeine
- ☐ Penicillin
- ☐ Sulfa
- ☐ Any other drug _____
- ☐ Environmental _____
- ☐ Insects _____
- ☐ Food _____

7. Acute Infectious Diseases

Please check those you have experienced.

- ☐ NONE
- ☐ Chicken Pox
- ☐ Diphtheria
- ☐ Infectious mononucleosis
- ☐ Hepatitis (Specify type) _____
- ☐ Measles (Rubeola)
- ☐ Measles (Rubella)
- ☐ Mumps
- ☐ Pneumonia
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Tonsillitis
- ☐ Other _____

8. Chronic Diseases/Conditions

Please check those you have experienced.

- ☐ NONE
- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Anxiety (Depression)
- ☐ Bleeding trait
- ☐ Cancer or malignancy
- ☐ Chronic bronchitis
- ☐ Chronic skin disease
- ☐ Concussion/head injury
- ☐ Convulsions or seizures (epilepsy)
- ☐ Diabetes
- ☐ Diseases of the colon
- ☐ Eating disorder
- ☐ Faint easily
- ☐ Gallbladder/liver disease
- ☐ Hay fever
- ☐ Headaches (recurrent)
- ☐ Hearing problem
- ☐ Heart disease
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Malaria
- ☐ Orthopedic problem (i.e., knee, back)
- ☐ Sinus infection (chronic)
- ☐ Sleep disorder
- ☐ Speech _____
- ☐ Thyroid or endocrine disturbance
- ☐ Tuberculosis
- ☐ Ulcer (stomach or duodenal)
- ☐ Visual _____
- ☐ Other _____

9. Female Menstrual History

Please check those that apply.

- ☐ Cramps
- ☐ Excessive flow
- ☐ Irregularity
- ☐ Do you miss classes because of menses?
- ☐ Have you received treatment for menstrual disorder?

10. Medication

- ☐ NONE

List medications prescribed by physician.

_____

_____

Other medication _____

Please refer to our web site,* **http://depts.loras.edu/StudentDevelopment/health/meningitis.html, *for more information about meningitis. We highly recommend that you are immunized for meningitis.*

11. I have received meningitis materials on the web site or requested by mail: _____

Signature of Student