Southwestern University Health Services

Immunization Records & Student Health Insurance

Proof of Immunizations

Proof of immunizations ("shots") is a requirement for admission to all institutions of higher education in the state of Texas. A complete immunization record includes your name, date of birth, and dates of all immunizations received throughout your lifetime.

Where You Can Find Your Shot/Immunization Records

Immunization records are usually available from your family physician, or often they can be found in your family records, such as a baby book, or a booklet given to your parents/guardians by your doctor at the time the immunizations were administered. If you are graduating from high school or transferring from another college or university, your school's nurse's or health services office may be able to print a copy of your immunization history/record.

Double-Checking Never Hurts

While receiving your required physical examination, consult with your doctor to be certain that you have received all immunizations specified for Southwestern students. (Please see page 2 of the Health Record form)

Some Form of Health Insurance is Required

Health insurance coverage, either through your parent's or other insurance provider, is mandatory for all students at Southwestern University. Students who have accidents or illnesses that cannot be treated on-campus are referred to physicians or hospitals in the area. Having health insurance coverage is critical in these situations; otherwise, the visit will be solely at the student's expense.

If you have private health insurance coverage, you will need to waive the student insurance and provide information regarding your private insurance. These can both be accomplished at http://www.eiiastudent.org/southwestern/.

Please be aware that if proof of insurance is not submitted, the Business Office will automatically bill you for the Educational Institutional Insurance Association (EIIA) plan, which is Southwestern University's student insurance provider.

Answers to Your Questions

Any questions regarding student health insurance may be directed to Health Services at 512-863-1252 or to the Business Office at 512-863-1928. Information is also available at http://www.eiiastudent.org/southwestern/.

Additional Contact Information

Health Services Office

Web: http://southwestern.edu/offices/health/

Phone: 512-863-1252

Fax: 512-863-1310

Where to Send Your Health Record Form

Completed Health Record and Athletics Clearance Forms should be mailed to the address below no later than July 1, 2012.

Dinorah Martinez-Anderson, RN, MSN, FNP-C
Director of Health Services
Southwestern University
PO Box 770
Georgetown, Texas 78627-0770

Southwestern University Health Record – 1 of 2

To the Student

IMPORTANT: EACH AND EVERY QUESTION MUST BE ANSWERED. INCOMPLETE RECORDS WILL BE RETURNED. THIS INFORMATION IS CONFIDENTIAL AND WILL NOT BE RELEASED WITHOUT YOUR CONSENT.

In order for you to register for classes, this record must be completed and returned to SU Health Services by July 1, 2012. ADDRESS: SU Health Services, P.O. Box 770, Georgetown, TX 78627-0770 FAX: 512-863-1310 PHONE: 512-863-1252

Please type or print in black or blue ink.

Student Information

Classification: ❍ First-Year ❍ Sophomore ❍ Junior ❍ Senior ❍ Transfer Date of Entrance:

last name | first name | middle | preferred name

birthdate (mm/dd/yyyy) | gender | citizenship

home address: street and number | city | state | zip | cell phone (include area code)

parent or guardian | relationship to student

parent address: street and number | city | state | zip

parent home phone (include area code) | parent cell phone (include area code) | parent business phone (include area code)

emergency contact: name | relationship to student | phone (include area code)

Family History

Father: ❍ Living ❍ Deceased
Occupation: _____
Age at Death _____
Cause of Death _____

Mother: ❍ Living ❍ Deceased
Occupation: _____
Age at Death _____
Cause of Death _____

Siblings
Number Living: _____
Number Deceased: _____
Do you have a twin? ❍ Yes ❍ No

Have any of your family members experienced the following? *(check all that are relevant)*

❍ Diabetes ❍ High Blood Pressure ❍ Heart Disease ❍ Kidney Disease ❍ Cancer (type: _____) ❍ Emotional Problems
❍ Psychiatric Problems ❍ Eating Disorders ❍ Depression ❍ Anxiety ❍ Alcoholism ❍ Substance Abuse ❍ Suicide

Personal History

Do you have, or have you had, any of the following? *(Y = Yes and N = No)*

❍ Y ❍ N - Asthma
❍ Y ❍ N - Cancer
❍ Y ❍ N - Diabetes
❍ Y ❍ N - Polio
❍ Y ❍ N - Tuberculosis
❍ Y ❍ N - Heart Disease
❍ Y ❍ N - Rheumatic Disease
❍ Y ❍ N - Seizures/Blackouts
❍ Y ❍ N - Other Chronic Illness

❍ Y ❍ N - Head Injury
❍ Y ❍ N - Recurrent Headaches
❍ Y ❍ N - High/Low Blood Pressure
❍ Y ❍ N - Anxiety/Depression
❍ Y ❍ N - Psychiatric Treatment
❍ Y ❍ N - Scarlet Fever
❍ Y ❍ N - German Measles
❍ Y ❍ N - Measles
❍ Y ❍ N - Chicken Pox

❍ Y ❍ N - Infectious Mononucleosis
❍ Y ❍ N - Appendectomy
❍ Y ❍ N - Tonsillectomy
❍ Y ❍ N - Hernia Repair
❍ Y ❍ N - Other Operations
❍ Y ❍ N - Menstrual Problems (females)
❍ Y ❍ N - Gum/Dental Disorder
❍ Y ❍ N - Bone/Joint Disease
❍ Y ❍ N - Kidney/Bladder Disease

❍ Y ❍ N - Wear Contact Lenses
❍ Y ❍ N - Wear Hearing Aid
❍ Y ❍ N - Other Disabilities/Needs
❍ Y ❍ N - Allergic to Penicillin?
❍ Y ❍ N - Allergic to Sulfa?
❍ Y ❍ N - Allergic to Codeine?
❍ Y ❍ N - Wasp/Bee Sting Allergy?
❍ Y ❍ N - Food Allergies?
❍ Y ❍ N - Receive Allergy Shots?

If you checked "yes" for any of the above, please attach *(on a separate sheet)* an explanation with relevant dates and information.

HEALTH INSURANCE Please provide Health Services with a copy of your insurance ID card *(front and back)*. Include name and address of primary policy holder.
I will use Private Insurance ❍ Yes ❍ No

AUTHORIZATION FOR MEDICAL PROCEDURES: Permission is hereby granted to Health Services at Southwestern University to authorize medical and surgical services, including physician ordered injections or required immunizations. In case of emergency, when the student is unconscious, Health Services is authorized and requested to refer the student to a duly licensed physician or hospital, and such physician or hospital is authorized to administer treatment or surgery as appears prudent under the circumstances then existing.

signature of student (if student is 18 years of age or over) | signature of parent or guardian (if student is 17 years of age or under)

Southwestern University Health Record – 2 of 2

To be Completed by Physician

We appreciate your thoroughness in completing this examination.

student name | date of birth (mm/dd/yyyy) | gender

temperature | pulse | blood pressure | height | weight

vision: right eye | left eye | corrected vision: right eye | left eye

Are all systems normal?
(describe fully)

- ❍ Yes ❍ No - Head, Ears, Nose or Throat
- ❍ Yes ❍ No - Skin
- ❍ Yes ❍ No - Respiratory
- ❍ Yes ❍ No - Cardiovascular
- ❍ Yes ❍ No - Gastrointestinal
- ❍ Yes ❍ No - Eyes (refractive)
- ❍ Yes ❍ No - Eyes (other)
- ❍ Yes ❍ No - Genitourinary
- ❍ Yes ❍ No - Musculoskeletal
- ❍ Yes ❍ No - Metabolic/Endocrine
- ❍ Yes ❍ No - Neuropsychiatric

Tuberculin Skin Test–PPD *(within last 12 months)*

date placed | date read | negative or positive results: circle one

if positive: chest x-ray results | medications

Is the patient currently under treatment for any medical or emotional condition? ❍ Yes ❍ No

if yes, please describe treatment plan

Is there loss/impaired function of any paired organ?
❍ No ❍ Yes:_____

Any recommendations regarding the care of this student?
❍ No ❍ Yes:_____

date of examination | physician's signature | physician's name (printed)

street address | city | state | zip | phone (include area code)

A complete immunization record is required for all Southwestern University students. Do not return this form until all required immunizations are received and recorded. Form must be returned by July 1, 2012.

Meningococcal Vaccine (*REQUIRED WITHIN LAST 5 YEARS*)

vaccination date

Diphtheria-Tetanus-Acellular Pertussis *(last dose within 7 years)*

vaccination dates

Polio

vaccination dates

Measles/Mumps/Rubella–MMR *(2 doses required or immune titer proof)*

vaccination date #1 | vaccination date #2 | or immune titer

Hepatitis B *(strongly recommended, but not required)*

vaccination date #1 | vaccination date #2 | vaccination date #3

HPV/Gardasil *(strongly recommended, but not required)*

vaccination date #1 | vaccination date #2 | vaccination date #3

date | physician's signature | physician's name (printed)

street address | city | state | zip | phone (include area code)

Southwestern University Athletics Clearance

Medical Clearance for Intercollegiate Athletics

To the Student

IMPORTANT: THIS FORM IS REQUIRED OF ALL INDIVIDUALS WHO DESIRE TO PARTICIPATE IN ANY INTERCOLLEGIATE ATHLETICS ACTIVITY WHILE ATTENDING SOUTHWESTERN UNIVERSITY.

TOP PORTION OF THIS FORM MUST BE COMPLETED BY YOUR PHYSICIAN.

student's last name | first name | middle initial | team sport(s)

Please list history of any orthopedic-related or head-related injuries

year	body part injured/head injury	diagnosis
year	body part injured/head injury	diagnosis
year	body part injured/head injury	diagnosis
year	body part injured/head injury	diagnosis

Please initial the appropriate line and enter comments at the bottom of the page:

_____ - From this evaluation, I have determined that the above patient IS physically fit and therefore CLEARED to participate in any intercollegiate athletics program at Southwestern University.

_____ - From this evaluation, I have determined that the above patient IS NOT physically fit and therefore NOT CLEARED to participate in any intercollegiate athletics program at Southwestern University.

_____ - From this evaluation, I have determined that the above patient NEEDS FOLLOW-UP CARE AND/OR TESTING in order to be cleared to participate in any intercollegiate athletics program at Southwestern University.

please list and explain any concerns or recommendations as they relate to the statements above

physician's signature | date

physician's name (printed) | phone (include area code)

Southwestern University Consent for Release

Informed Consent for Release of Information

To the Student

The Athletic Training Department is now using the SOUTHWESTERN UNIVERSITY STUDENT HEALTH RECORD to serve as the primary health clearance for participation in the intercollegiate athletics program. We are required to have a copy of the physical on-file in our office before any individual can participate. We must request a copy of your Health Record from Health Services. Please understand that we are only asking for a copy of the Health Record submitted to Health Services to begin your file with us.

I HEREBY AUTHORIZE HEALTH SERVICES TO RELEASE INFORMATION TO SOUTHWESTERN UNIVERSITY ATHLETIC TRAINERS AND TEAM PHYSICIANS. I UNDERSTAND THAT MY RECORDS ARE PROTECTED BY FEDERAL LAW AND CANNOT BE DISCLOSED WITHOUT THIS WRITTEN CONSENT UNLESS OTHERWISE PROVIDED IN FEDERAL REGULATIONS. I MAY REVOKE THIS CONSENT AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN. MY SIGNATURE ALSO MEANS I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS.

student's/patient's signature | student's/patient's name printed | date