

NORTHWEST

missouri / state / university / maryville

UNIVERSITY WELLNESS CENTER

800 University Drive ■ Maryville, MO 64468 ■ 660.562.1348 ■ fax: 660.562.1585 ■ e-mail: health@nwmissouri.edu

CONGRATULATIONS ON BEING ACCEPTED TO NORTHWEST!

ABOUT THE UNIVERSITY WELLNESS CENTER

The University Wellness Center is the hub for all campus health services. This encompasses medical, personal development and counseling, health promotion, public health, emergency response and institutional testing services.

While remaining committed to quality outpatient care, we focus on wellness, not only as prevention of disease, but also as a philosophy of life. This philosophy emphasizes self-responsibility and taking an active role in maintaining one's health. We believe true health must consider the individual as an integration of mind, body and spirit. Please visit www.nwmissouri.edu/wellnesscenter for more information.

HEALTH INSURANCE

HEALTH INSURANCE INFORMATION

The University Wellness Center has the capability to bill your insurance company for the services provided through our third-party billing company, Highland Campus Health Group. If you have health insurance, please do the following:

- Submit copies of both the **front and back** of your health insurance card to the University Wellness Center
- Contact your insurance company to make sure we are an in-network provider
- Ask your insurance company about an "away program" that you may need to enroll in to have services covered

Northwest offers University insurance coverage through Columbian Life. For more information, please contact the Bursar's Office at 660.562.1578.

PLEASE COMPLETE THIS ENTIRE FORM BY THE FOLLOWING DATES:

Fall Trimester – August 1
Spring Trimester – December 1
Summer Trimester – April 1

Please return directly to the Wellness Center, DO NOT submit with other Admissions materials.

If you have a disability or significant health problem, please contact the Wellness Center before coming to campus.

NORTHWEST MISSOURI STATE UNIVERSITY

UNIVERSITY WELLNESS CENTER HEALTH HISTORY FORM

OFFICE USE ONLY

Date Received _____

I-9 Number _____

PERSONAL INFORMATION

Last name (Maiden name) First Middle

Address City State ZIP

(_____) _____
Phone Cell Phone Date of Birth

Country of birth Social Security Number Male Female

EMERGENCY CONTACT INFORMATION

Name Relationship

Address City State/Country ZIP

(_____) _____
Home Phone Work Phone

Primary Care Provider Address Phone Fax

MEDICAL HISTORY

Do you have a present or past history of the following: (check all that apply)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Intestinal/stomach trouble | <input type="checkbox"/> Rubella (3-day measles) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Ear trouble/hearing loss | <input type="checkbox"/> Joint disease/injury | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Measles, Red | <input type="checkbox"/> Sexually trans. infection (STI) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eye disease/problems | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Sickle Cell Trait/Anemia |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Gallbladder trouble | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hay fever (recurrent) | <input type="checkbox"/> Mononucleosis, infectious | <input type="checkbox"/> Skin problems (chronic) |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Head injury | <input type="checkbox"/> Mumps | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Headache (recurrent) | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Smoking (how long?) _____ |
| <input type="checkbox"/> Cough (chronic) | <input type="checkbox"/> Heart disease/problems | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Spleen, surgical removal |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Polio | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hernia/rupture | <input type="checkbox"/> Psychological counseling | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Disability/Handicap | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Other _____ | | | |

CURRENT MEDICATIONS (list all, including birth control)

ALLERGIES

HOSPITALIZATIONS/SURGERIES

FAMILY HISTORY (PLACE RELATIONSHIP IN BLANK)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Alcohol/drug abuse _____ | <input type="checkbox"/> Death before 50 _____ | <input type="checkbox"/> Elevated cholesterol _____ | <input type="checkbox"/> Hypertension/stroke _____ |
| <input type="checkbox"/> Cancer/type _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Mental illness _____ |

CONSENT FOR TREATMENT

STUDENTS UNDER 18

I grant permission to the medical staff at the University Wellness Center, Northwest Missouri State University, to treat my son/daughter as may be necessary, and to refer to private care when special service is needed.

PARENT/GUARDIAN SIGNATURE

DATE

FOR ALL STUDENTS

By signature, I verify that the information provided on the form is true and I give permission for such diagnosis, therapeutic and operative procedures as may be deemed necessary for me.

STUDENT SIGNATURE

DATE

VACCINATION AND EDUCATION REQUIREMENTS

In addition to the required vaccination information requested below, please send us copies of any other vaccination records that you may have.

MEASLES, MUMPS AND RUBELLA (MMR) VACCINATION

REQUIRED FOR ALL STUDENTS

Northwest Missouri State University policy requires that ALL newly enrolled students born after 1956 must comply with the two dose Measles Vaccination Policy. Students who do not comply will have a hold put on their registration for future classes.

SUBMIT TO THE UNIVERSITY WELLNESS CENTER THE FOLLOWING:

- Documentation of **two doses of the MMR vaccine.**
The first dose must have been given at age 12 months or later. The second dose must have been at least one month after the first dose.
- OR**
- Documentation of a **TITER**, which is a blood test proving immunity to Measles (Rubeola), Mumps and Rubella.

MENINGOCOCCAL EDUCATION AND VACCINATION REQUIREMENT

REQUIRED FOR ALL STUDENTS LIVING ON CAMPUS

All students who will reside in residence halls at Northwest Missouri State University must review information on meningococcal disease and vaccine at <http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-mening.pdf>. A student will not be allowed to move into the residence halls until he/she has completed this requirement.

SUBMIT TO THE UNIVERSITY WELLNESS CENTER THE FOLLOWING:

- Documentation of **one dose of meningococcal vaccine.**
- OR**
- **Sign the waiver form below.**

WAIVER

By signing this waiver, I have read the information on the risks of meningococcal disease and am aware of the effectiveness of the vaccine and its availability at the University Wellness Center. I am aware that meningococcal disease is a rare but life-threatening illness. I understand that Northwest policy requires that students residing in on-campus housing be vaccinated against meningococcal disease or sign a waiver. With this waiver, I seek exemption from this requirement. I voluntarily agree to release, discharge, indemnify and hold harmless Northwest Missouri State University, its officers, employees and agents from any and all costs, liabilities, expenses, claims or causes of action on any account of any loss or personal injury that might result from my decision not to be immunized against meningococcal disease.

STUDENT NAME (PLEASE PRINT)

STUDENT SIGNATURE

DATE

PARENT/GUARDIAN SIGNATURE (IF STUDENT IS UNDER 18 YEARS OF AGE)

DATE

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

- Have you ever had a positive TB skin test? YES NO
- Have you ever had close contact with anyone who was sick with TB? YES NO
- Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years?
(If yes, please CIRCLE the country) YES NO
- Have you ever traveled to/in one or more of the countries listed below?
(If yes, please CHECK the country/ies and indicate when) YES NO

Afghanistan	Central Africa	Guatemala	Maldives	Paraguay	Swaziland
Algeria	Rep.	Guinea	Mali	Peru	Tajikistan
Angola	Chad	Guinea-Bissau	Marshall Islands	Philippines	Tanzania-UR
Anguilla	China	Guyana	Mauritania	Poland	Thailand
Argentina	Colombia	Haiti	Mauritius	Portugal	Timor-Leste
Armenia	Comoros	Honduras	Mexico	Qatar	Togo
Azerbaijan	Congo	India	Micronesia	Romania	Tokelau
Bahamas	Congo DR	Indonesia	Moldova-Rep.	Russian	Tonga
Bahrain	Cote d'Ivoire	Iran	Mongolia	Federation	Tunisia
Bangladesh	Croatia	Iraq	Montenegro	Rwanda	Turkey
Belarus	Djibouti	Japan	Morocco	St. Vincent &	Turkmenistan
Belize	Dominican	Kazakhstan	Mozambique	The Grenadines	Tuvalu
Benin	Republic	Kenya	Myanmar	Sao Tome &	Uganda
Bhutan	Ecuador	Kiribati	Namibia	Principe	Ukraine
Bolivia	Egypt	Korea-DPR	Nauru	Saudi Arabia	Uguguay
Bosnia and	El Salvador	Korea-Republic	Nepal	Senegal	Uzbekistan
Herzegovina	Equatorial Guinea	Kuwait	New Caledonia	Seychelles	Vanautu
Botswana	Eritrea	Krygyzstan	Nicaragua	Sierra Leone	Venezuela
Brazil	Estonia	Lao PDR	Niger	Singapore	Vietnam
Brunei	Ethiopia	Latvia	Nigeria	Solomon Islands	Wallis and Futuna
Darussalam	Fiji	Lestho	Niue	Somalia	Islands
Bulgaria	French Polynesia	Liberia	North Mariana	South Africa	West Bank and
Burkina Faso	Gabon	Lithuania	Islands	Spain	Gaza Strip
Burundi	Gambia	Macedonia-TFYR	Pakistan	Sri Lanka	Yemen
Cambodia	Georgia	Madagascar	Palau	Sudan	Zambia
Camerron	Ghana	Malawi	Panama	Suriname	Zimbabwe
Cape Verde	Guam	Malaysia	Papua Ne Guinea	Syrian Arab Rep.	

Source: World Health Organization Global Tuberculosis Control, WHO Report 2006, Countries with Tuberculosis incidence rates of ≥ 20 cases per 100,000 populations. For future updates, refer to www.who.int/globalatlas/dataQuery/default.asp

If you answered **YES** to any of the above, you must:

- **Schedule a TB test** at the University Wellness Center
- OR
- **Documentation of a TB test done in the United States** within the past 12 months. TB tests done outside of the United States will not be excepted.

Chest X-rays will be required for anyone with a positive test.