Welcome to Northwest!

The University Wellness Center is your first stop to success at Northwest. The documentation listed below must be submitted to health@nwmissouri.edu PRIOR to your arrival to campus. Once received, you will be issued an appointment with Wellness Services. This appointment time is carefully selected to coordinate with your arrival time. You MUST be on-time for this appointment. Failure to comply with these guidelines will impede the orientation process.

We Look forward to Meeting you!

Compliance Checklist

› Physician Verification – Must be completed by a physician – Page 2
  ■ Proof of Two (2) MMR Vaccinations
  ■ Proof of One (1) Meningococcal Conjugate Vaccine after the age of 16 (If living on campus)
    - The cost of each required vaccine is high, therefore, we highly encourage you to receive these vaccines prior to coming to Northwest.
› Northwest Missouri State University’s Health History Form – Pages 3 & 4
› Written documentation of ANY treatment for active TB infection

Insurance Information

Below you will find some helpful contact information for LewerMark:

■ LewerMark Customer Services Toll Free: 800-821-7710 (Monday – Friday 8:00 a.m. – 6:00 p.m.)
■ Website: www.lewermark.com
■ Email: lewermarksupport@lewer.com
■ Northwest School Webpage: www.lewermark.com/nwmissouri
■ My nurse 24/7: 866-549-5076 (provides you with free access to speak to a nurse regarding your health questions)

THIS FORM, AND IMMUNIZATION RECORDS, MUST BE COMPLETED AND SUBMITTED BY THE FOLLOWING DATES:

Fall Trimester – Aug. 1
Spring Trimester – Dec. 1
Summer Trimester – April 1

Please return directly to Wellness Services, DO NOT submit with other Admissions materials.
Failure to submit this required information by these dates can result in a hold being placed on your account - please return all forms completed by the specified dates.

If you have a disability or significant health problem, please contact Wellness Services before coming to campus.
Vaccination 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 have two MMRs at least 28 days apart.

**Meningococcal vaccination requirement**

**Required for all students living on campus**

Effective July 1, 2016, Missouri state law requires all students residing in residence halls have received the conjugate vaccine (or a booster dose) after the age of 16 and within five years of initial enrollment.

**Physician Verification**

(Required if living on campus)

Name of Student __________________________ Date of Birth: __________________________

**Measles Mumps Rubella (MMR)**

(You must have had 2 of these vaccines at least 28 days apart)

DATE OF DOSE 1: __________________________

DATE OF DOSE 2: __________________________

**(Required if living on campus)**

DATE OF DOSE: __________________________

Please list any other vaccines you have had:

__________________________________________

If you have had prior treatment for active TB disease or latent TB infection medication treatment, written documentation must be submitted prior to arrival.

Student Signature __________________________________________ Date ________________

Signature of parent (if student is under 18 years of age) ________________

Signature of Health Care Provider __________________________________________ Date ________________

**Official seal of hospital or clinic** (must have official seal to make this a valid document)
Health History Form - International Students

Personal information

Last name ___________________________ (Maiden name) ___________________________ Legal First Name ___________________________ Middle ___________________________ Preferred Name ___________________________

Address ___________________________ City ___________________________ State ___________________________ ZIP ___________________________

Phone ___________________________ Student’s U.S. Cell phone ___________________________ Cell Phone Carrier ___________________________

Date of birth ___________________________ Country of birth ___________________________

Preferred Spoken Language(s) ___________________________

Medical history

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

- Alcohol abuse
- Anemia
- Anxiety
- Arthritis
- Asthma
- Back problems
- Cancer
- Convulsions/Seizures
- Cough (chronic)
- Depression
- Diabetes
- Disability/Handicap
- Other

- Drug abuse
- Ear trouble/hearing loss
- Eating disorder
- Eye disease/problems
- Gallbladder trouble
- Hay fever (recurrent)
- Head injury
- Headache (recurrent)
- Heart disease/problems
- Hepatitis/Jaundice
- Hernia/rupture
- High blood pressure
- Intestinal/stomach trouble/colitis
- Joint disease/injury
- Measles, Red
- Menstrual problems
- Migraine headaches
- Mononucleosis, infectious
- Mumps
- Pneumonia
- Paralysis
- Polio
- Psychological counseling
- Rheumatic fever
- Rubella (3-day measles)
- Scarlet fever
- Sexually trans. infection (STI)
- Sickle Cell Trait/Anemia
- Sinus trouble
- Skin problems (chronic)
- Sleep problems
- Smoking (how long?)
- Spleen, surgical removal
- Thyroid disease
- Tuberculosis
- Urinary tract infection
- NONE OF THE ABOVE

Current medications (list all, including birth control) ___________________________ ___________________________ ___________________________

Do you have allergies to drugs, foods, metals? Yes / No ___________________________ ___________________________ ___________________________

Hospitalizations/surgeries ___________________________ ___________________________ ___________________________

☐ N/A ☐ N/A ☐ N/A

Family history (place relationship in blank)

- Alcohol/drug abuse ___________________________ Death before 50 ___________________________ Elevated cholesterol ___________________________

- Cancer/type ___________________________ Diabetes ___________________________ Heart disease ___________________________

- Hypertension/stroke ___________________________

- Mental illness ___________________________

HIPAA Notice of Privacy Practices Acknowledgment

By signing below I acknowledge receipt of Wellness Service’ Notice of Privacy Practices, which is available to me at:

https://www.nwmissouri.edu/wellness/PDF/NoticeOfPrivacyPractices.pdf

By signing below I acknowledge that this serves as a consent to receive treatment from Wellness Services, as outlined here: https://www.nwmissouri.edu/wellness/PDF/TreatmentAgreement.pdf

Student Signature ___________________________ Date: ___________________________

Students Under 18

I grant permission to University Wellness Services (to include clinic, counseling, and health education services) 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: ___________________________
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 the date(s) and duration of travel) □ YES □ NO

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015. Countries with incidence rates of ≥ 20 cases per 100,000 population.
For further updates, refer to http://www.who.int/tb/country/en/

Additional American College Health Association immunization recommendations:
• Polio
• Tetanus, Diphtheria, Pertussis
• Varicella
• Human Papillomavirus
• Hepatitis A
• Hepatitis B
• Influenza
• Pneumococcal

For more information contact University Wellness Services.