



2010-2011

## Student Health Office

# Health Office Services & Requirements

Send Completed Form to:

Student Development Office

1311 South Ninth Street

Omaha, Nebraska 68108-3629

www.GraceU.edu

Phone: 402-449-2923

### Grace University Student Health Office

- The Grace University Student Health Office offers non-acute primary care, basic medical treatment and evaluation provided by a Registered Nurse. It is a walk-in clinic. Sports physicals (a requirement to play any sport at GU) may be obtained through the Health Office each fall semester. Some over-the-counter medicines, immunizations and flu shots can also be obtained through the Health Office.
- Services are available for all students of Grace University, spouses and children. Most services through the Health Office are free of charge. However, there is a charge for Strep throat and mono testing and immunizations. The student is responsible for these costs which can be charged to the student's Grace Account. Personal health insurance is **highly recommended** for services provided by hospitals or physicians. If the student is still under the parent's insurance, a copy of the parent's insurance card is **necessary** for referrals to MDs, ERs, or the hospital.
- All medical information is treated as confidential, and may only be released by written permission of the student.

### New Student Checklist: Enrollment will not be complete without the following information:

1. **Proof of Health Insurance** for all student intercollegiate athletes and non-U.S. citizens.  
While health insurance is not required for other students it is *strongly* recommended that all students have insurance coverage while in school.
2. **Information regarding family and personal history** (Please provide on enclosed form)
3. **Proof of Immunity Against:**  
MMR (Measles, mumps, rubella) x 2 - 1<sup>st</sup> at 15 months of age or older, 2<sup>nd</sup> after 5 years of age/after Jan. 1980  
Diphtheria / Tetanus (within last 10 years)  
Mantoux TB (skin) testing (within last year)  
Hepatitis B series (series of 3)  
**PLEASE PROVIDE DATES FOR THESE IMMUNIZATIONS ON THE ENCLOSED FORM**
4. **Verification of Immunity Against OR Verification of Being Informed about Risk For Meningitis and Refusal of it** (Please note the enclosed brochure with information regarding this vaccine and mark your option on the enclosed form.)

**NOTE:** If a student has not had the immunizations listed above they may receive them during registration. The cost for immunizations vary. The following prices are estimates for the 2010-2011 school year:

TB Skin test - \$10	Diphtheria/Tetanus - \$42
MMR - \$56	Meningitis - \$90
Hepatitis B series (3 shots) - \$40/shot	

### Health Office Staff

Cindy Costello, RN BSN is the resident nurse at the Health Office of Grace University. In addition to serving as the nurse for Grace University, Cindy is also the Academic Advisor for all Grace nursing students.

Cindy graduated from Grace University in 1991 with her BS. She and her family then spent 10 years as missionaries in Costa Rica and Spain. She graduated from Creighton University in 2005 with her BSN. Professional nursing experience includes Intensive Care and Generalized Medical-Surgical Home Health Care.

# Confidential Health History

ALL MEDICAL INFORMATION IS TREATED AS CONFIDENTIAL, AND MAY ONLY BE RELEASED BY WRITTEN PERMISSION OF THE STUDENT.

Original Date: \_\_\_/\_\_\_/\_\_\_ Date Revised: \_\_\_/\_\_\_/\_\_\_ \_\_\_/\_\_\_/\_\_\_ \_\_\_/\_\_\_/\_\_\_

## STUDENT INFORMATION

Name: \_\_\_\_\_  M **Social Security #:** \_\_\_\_\_  
*Last, First, M.I.*  F

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Country of Birth: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Country of Citizenship: \_\_\_\_\_

Student Status:  Freshman  Sophomore  Junior  Senior  Graduate  EXCEL

Marital Status:  Single  Engaged  Married  Separated  Divorced  Widowed

## EMERGENCY CONTACT INFORMATION

Home Address: \_\_\_\_\_ Home Number: (\_\_\_\_) \_\_\_\_\_  
*Street*  
\_\_\_\_\_  
*City/ State/ Zip*

Emergency Contact: \_\_\_\_\_ Home Number: (\_\_\_\_) \_\_\_\_\_  
Relationship: \_\_\_\_\_ Work Number: (\_\_\_\_) \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_  
*Street City/ State/ Zip*

## HEALTH INSURANCE

Please note: Proof of Health Insurance is required for all student athletes and international students, and is strongly recommended for all other students.

Are you presently covered by health insurance?  Yes  No Coverage Effective : \_\_\_\_\_ to \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Address for Claims: \_\_\_\_\_  
*Street (must be provided for processing)*  
\_\_\_\_\_  
*City/ State/ Zip* Group Number: \_\_\_\_\_

Name of Employer (if provider of insurance): \_\_\_\_\_ Home Number: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ Work Number: (\_\_\_\_) \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Social Security Number of Policy Holder: \_\_\_\_\_  
Relationship to Policy Holder: \_\_\_\_\_

## RISK FOR MENINGITIS

I have read the enclosed information about meningitis and understand that all on-campus housing students and their parents must be informed of the risks associated with the potentially fatal meningococcal disease and the availability of an effective vaccine to prevent the disease (which is strongly recommended by the AMA & ACHA). I am aware that Grace University offers the immunization.

\_\_\_\_\_ I am declining the immunization at this time.

\_\_\_\_\_ Please reserve an immunization for me (\$90), which I will receive during registration in August.

## AUTHORIZATION- All attempts will be made to contact the parent before emergency medical treatment.

I hereby give consent to medical personnel associated with Grace University to provide general and emergency treatment they deem appropriate and to make medical referrals for the above student during his/her attendance at Grace University. I fully understand that I am legally responsible for any medical expenses incurred during my enrollment at Grace University, and the University will not be held responsible for any medical expenses. This information is restricted to the use of limited personnel at Grace University and the Student Health Office, and will not be released without the student's knowledge or consent.

Student Signature \_\_\_\_\_

Date \_\_\_\_\_

Signature of Parent or Guardian (if student is age 18 or under) \_\_\_\_\_

Date \_\_\_\_\_



# PARENT'S INSURANCE FORM FOR STUDENT ATHLETICS

Please note: Students cannot participate in PRACTICES or games until this form is completed.

Athlete's Name: \_\_\_\_\_  
Last, First, M.I.

M  
 F

Social Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_

Dear Parent:

Grace University carries an athletic accident policy for our intercollegiate athletes for any injuries incurred during practice for and/or the play of intercollegiate sports. This policy is a "SECONDARY" policy in that it does not consider claims until after any "PRIMARY" policies have considered the claims. This means that any claim for benefits must **first** be filed with the student's parent's health insurance (s); and **then**, Grace's athletic insurance company will consider any remaining amounts.

**Please Note:**

- Any remaining charges after both insurance companies (1-your insurance company(s) / 2-Grace athletic insurance company) have processed a claim, will be the sole responsibility of the student and his/her parents.
- The filing of claims with both the parent's insurance company(s) and with the Grace athletic insurance company are the responsibility of the student and his/her parents.

**Father/Mother/Guardian/Spouse/Self (circle one)**

Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City/ State/ Zip Code

Home Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
Street City/ State/ Zip Code

Name of Group Insurance Company: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address for Claims: \_\_\_\_\_  
Street City/ State/ Zip Code

Does your insurance require:

A second opinion for surgery? YES \_\_\_\_\_ NO \_\_\_\_\_ Is your primary insurance an HMO? YES \_\_\_\_\_ NO \_\_\_\_\_

Pre-authorization for services? YES \_\_\_\_\_ NO \_\_\_\_\_ Is your primary insurance a PPO? YES \_\_\_\_\_ NO \_\_\_\_\_

IS YOUR DEPENDENT SON/DAUGHTER COVERED UNDER THE ABOVE POLICY? YES \_\_\_\_\_ NO \_\_\_\_\_

**Father/Mother/Guardian/Spouse/Self (circle one)**

Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City/ State/ Zip Code

Home Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
Street City/ State/ Zip Code

Name of Group Insurance Company: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address for Claims: \_\_\_\_\_  
Street City/ State/ Zip Code

Does your insurance require:

A second opinion for surgery? YES \_\_\_\_\_ NO \_\_\_\_\_ Is your primary insurance an HMO? YES \_\_\_\_\_ NO \_\_\_\_\_

Pre-authorization for services? YES \_\_\_\_\_ NO \_\_\_\_\_ Is your primary insurance a PPO? YES \_\_\_\_\_ NO \_\_\_\_\_

IS YOUR DEPENDENT SON/DAUGHTER COVERED UNDER THE ABOVE POLICY? YES \_\_\_\_\_ NO \_\_\_\_\_

*I hereby give consent to medical personnel and coaches associated with Grace University to provide general and emergency treatment they deem appropriate and to make medical referrals for the above student during his/her attendance at Grace University. I fully understand that I am legally responsible for any medical expenses incurred during my enrollment at Grace University, and the University will not be held responsible for any medical expenses. This information is restricted to the use of limited personnel at Grace University and the Student Health Office, and will not be released without the student's knowledge or consent.*

Student Signature \_\_\_\_\_

Date \_\_\_\_\_

Signature of Parent or Guardian (if student is covered under a parent's insurance) \_\_\_\_\_

Date \_\_\_\_\_

## GRACE UNIVERSITY STUDENT ATHLETES ONLY

<b>Athlete's Name:</b> _____ <div style="display: flex; justify-content: space-between; font-size: small;"> <span><i>Last,</i></span> <span><i>First,</i></span> <span><i>M.I.</i></span> </div>	<input type="checkbox"/> M <input type="checkbox"/> F	<b>Social Security #:</b> _____ - _____ - _____
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**What sports are you interested in at Grace?** \_\_\_\_\_

Have you had:	Yes	No	Health-Care History	Yes	No
Allergies (hay fever, food...)			Have you been told not to participate in any sport?		
Close relative with heart problems before age 40			Have you been a patient in a hospital for an operation or any other reason? If so, what?		
Black-out or fainting during exercise			Are you injured or ill now?		
Fracture or dislocation			Have you had any other serious injuries?		
Knee or ankle sprain (left or right)			Do you take any kind of medicine every day? If so, what?		
Memory loss or unconsciousness due to a blow to your head			Is there any other pertinent information you feel we need to know?		

## SPORTS PHYSICAL – TO BE COMPLETED BY A PHYSICIAN

Age _____ Height _____ Weight _____ Blood Pressure _____ Hct _____ UA _____ Eyes R _____ L _____ Ears R _____ L _____ Nose _____ Sinuses _____ Throat/ Mouth _____ Skin _____	Respiratory _____ Cardiovascular _____ Liver _____ Spleen _____ Abdomen _____ Hernia R _____ L _____ Genitalia _____ Musculoskeletal _____ Knees _____ Ankles _____ Neurological _____	<b>Other history we should know:</b> _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
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*I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me. I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities except those **CROSSED OUT BELOW**.*

BASKETBALL      SOCCER      VOLLEYBALL

\_\_\_\_\_  
Dr. Signature

\_\_\_\_\_  
Date of Examination

