2015-2016
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 are charges 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 ins-
  urance is highly recommended for services provided by hospitals or physicians. Students should carry a copy
  of the health insurance card as this information 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 is required.
   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 Confidential Health Form)
3. Proof of Immunity Against:
   MMR (measles, mumps, rubella) x 2 - 1st at 15 months of age or older, 2nd after 5 years of age/after Jan.1980
   Diphtheria / Tetanus (within last 10 years)
   Mantoux TB (skin) testing (within 3 months)
   Hepatitis B series (series of 3)
   PLEASE PROVIDE DATES FOR THESE IMMUNIZATIONS
   ON THE ENCLOSED
   CONFIDENTIAL HEALTH 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 Confidential Health Form.)

NOTE: If a student has not had the immunizations listed above they may receive them during registration.

Health Office Staff
Thalia Crum, RN BSN is the resident nurse at the Health Office of Grace University. In addition to serving as the
nurse for Grace University, she is also the Academic Advisor for all Grace nursing students.
Thalia graduated from College of Saint Mary in 2007 with her BS. She is currently working on her Masters in mental
health counseling here at Grace University. When she is not at Grace, she is working as a case manager missions
nurse for the Visiting Nurse Association of the Midlands. She also serves as an interpreter for the VNA staff as a
Spanish speaking interpreter.
# 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

<table>
<thead>
<tr>
<th>Name: ___________________________</th>
<th>Social Security #: __<em><strong><strong><strong><strong>-</strong></strong>_<strong><strong>-</strong></strong></strong></strong></em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Last, First, M.I.</td>
<td></td>
</tr>
<tr>
<td>Date of Birth: <strong><strong><strong>/</strong></strong><em>/</em></strong>___</td>
<td>Age: ______</td>
</tr>
<tr>
<td>Height: ______</td>
<td>Weight: ______</td>
</tr>
</tbody>
</table>
| Student Status:  
- [ ] Freshman  
- [ ] Sophomore  
- [ ] Junior  
- [ ] Senior  
- [ ] Graduate  
- [ ] EXCEL |
| Marital Status:  
- [ ] Single  
- [ ] Engaged  
- [ ] Married  
- [ ] Separated  
- [ ] Divorced  
- [ ] Widowed |

## EMERGENCY CONTACT INFORMATION

| Home Address:  
- Street  
- City/ State/ Zip |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Number: (____)</td>
<td></td>
</tr>
<tr>
<td>Emergency Contact: ____________________________</td>
<td>Home Number: (____)</td>
</tr>
<tr>
<td>Relationship: ____________________________</td>
<td>Work Number: (____)</td>
</tr>
<tr>
<td>Family Physician: ____________________________</td>
<td>Phone Number: (____)</td>
</tr>
</tbody>
</table>
| 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  
- 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, which I will receive during registration in August.

## AUTHORIZATION

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.

<table>
<thead>
<tr>
<th>Student Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of Parent or Guardian (if student is age 18 or under)</td>
<td>Date</td>
</tr>
</tbody>
</table>
I certify that the above information (personal information, health and family history, immunization record) is complete and accurate to the best of my knowledge. I understand that all charges for health care treatment while I am enrolled at Grace University are my responsibility.

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**RECORD OF REQUIRED IMMUNIZATIONS**

<table>
<thead>
<tr>
<th>Childhood Illnesses:</th>
<th>☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ ________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunizations and Dates:</td>
<td>☐ Diphtheria/Tetanus /</td>
</tr>
<tr>
<td>☐ Hepatitis B / /</td>
<td>☐ MMR #1 /</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella</td>
<td></td>
</tr>
<tr>
<td>☐ TB / /</td>
<td></td>
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</tbody>
</table>

Proof of two doses of live measles vaccine given after the age of 15 months is required of all students born after 1957.

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**PERSONAL HEALTH HISTORY**

- **Medications (Prescription and/or over-the-counter):**
- **Allergies (e.g., medications, food, other):**
- **Have You Had:**
  - Yes / No
  - Other Diseases Continued…
  - Yes / No
  - Acute Infectious Diseases
  - Migraine headaches
  - Hepatitis
  - Speech, Hearing, Vision Problems
  - Infectious Mononucleosis (Mono)
  - Thrombophlebitis
  - Pneumonia
  - Thyroid or Endocrine Disturbance
  - Tonsillitis
  - Tuberculosis
  - Typhoid
  - Other
  - Sexually Transmitted Diseases
  - Health-Care History
  - Yes / No
  - Other Diseases
  - Have you been hospitalized?
  - Yes / No
  - Alcoholism/Drug Addiction
  - Have you had any surgical operations?
  - Yes / No
  - Anemia
  - Are you under medical treatment?
  - Yes / No
  - Anorexia/Bulimia
  - Do you have a physical handicap?
  - Yes / No
  - Asthma
  - Are you under care of the State?
  - Yes / No
  - Cancer
  - Have you been advised to seek psychological help?
  - Yes / No
  - Chronic Bronchitis
  - Have you received psychological care?
  - Yes / No
  - Chronic Skin Disease (eczema, psoriasis)
  - Other
  - Convulsions, Seizures (epilepsy)
  - For Females Only:
  - Yes / No
  - Dental Problems
  - Severe cramps
  - Diabetes
  - Excessive flow
  - Digestive Tract Disease (ulcer, colitis)
  - Bleeding between periods
  - Gallbladder/Liver Disease
  - Severe mood swings
  - Glaucoma
  - Any urinary tract, bladder or kidney infections within the last year?
  - Health-Related Behaviors
  - Yes / No
  - Hay Fever
  - For Females Only:
  - Yes / No
  - Heart Disease (rheumatic fever, murmur)
  - Are you a current or past cigarette smoker?
  - High Blood Pressure
  - Do you consume alcohol on a regular basis?
  - HIV Infection
  - Do you exercise on a regular basis?
  - Kidney or Bladder Disease
  - Do you keep track of your dietary fat intake?
  - Malaria
  - Do you know your current cholesterol level?
  - Any additional comments:

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**FAMILY HEALTH HISTORY**

- **Have any relatives (parents, siblings, grandparents) suffered from the following diseases:**
  - Yes / No
  - Asthma
  - Kidney Disease
  - Abnormal Bleeding
  - High Blood Pressure
  - Arthritis
  - Mental Disorder
  - Cancer
  - Migraines
  - Diabetes
  - Seizures
  - Glaucoma
  - Thyroid
  - Heart Disease
  - Tuberculosis
  - Other history we should know:

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Student Signature

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