



2017-2018

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. Some over-the-counter medicines, immunizations and flu shots can also be obtained through the Health Office. Allergy shots can be administered using the student's own doctor/allergist provided allergy serum. Sports physicals will be taken care of by the Athletic Department when athletes arrive on campus.
- 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 and other additional procedures. The student is responsible for these costs; which can be charged to the student's Grace Account. Personal health insurance is **required** 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.

New Student Checklist: Move-In will not be permitted without the following information:

1. **Proof of Health Insurance** for all student is required.
 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 2 months)
 - Hepatitis B series (series of 3)
- PLEASE PROVIDE A HARD COPY OF THE ABOVE LISTED IMMUNIZATIONS.
IN ADDITION TO COMPLETING THE 'RECORD OF REQUIRED IMMUNIZATIONS' SECTION
OF 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 request them in advance through the health office; once purchased they are non-refundable.

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 and from Grace University in 2015 with an MA in Counseling. She is currently working on her Masters in Christian Ministry here at Grace University. When she is not at Grace, she is working at UNMC with the oncology/hematology unit at the Fred and Pamela Buffet Cancer Center. She also teaches and administers the state exams for a CNA/CMA school on a part time basis.

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: _____
Last, First, M.I.

M
 F

Social Security #:

_____-_____-_____

Date of Birth: ___/___/___
Height: _____

Age: _____
Weight: _____

Country of Birth: _____
Country of Citizenship: _____

Student Status: Freshman Sophomore Junior Senior Campus Resident? Yes No

Marital Status: Single Engaged Married Separated Divorced Widowed

EMERGENCY CONTACT INFORMATION

Home Address: _____
Street

City/ State/ Zip

Home Number: (____) _____

Cell Number: (____) _____

Emergency Contact: _____
Relationship: _____

Primary Phone: (____) _____

Other Phone: (____) _____

Family Physician: _____
Address: _____
Street

Phone Number: (____) _____

City/ State/ Zip

HEALTH INSURANCE

Please note: Proof of Health Insurance is required for all students.

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

Insurance Company: _____
Address for Claims: _____
Street

City/ State/ Zip

Policy Number: _____
(must be provided for processing)

Group Number: _____

Name of Employer (if provider of insurance): _____
Address: _____

Phone Number: (____) _____

Name of Policy Holder: _____
Relationship to Policy Holder: _____

Social Security Number of Policy Holder:

_____-_____-_____

RISK FOR MENINGITIS

(INITIAL APPLICABLE LINE)

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 understand and accept the risk of not getting immunized at this time.
 _____ Please reserve an immunization for me, which I will receive during registration in August.
 _____ I have already been vaccinated and will provide records to verify.

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

RECORD OF REQUIRED IMMUNIZATIONS

Childhood Illnesses and Dates:

- Measles (____/____)
- Mumps (____/____)
- Rubella (____/____)
- Chickenpox (____/____)
- Rheumatic Fever (____/____)
- _____ (____/____)

Immunizations and Dates:

Diphtheria/Tetanus _____ / _____

Meningitis

Men ACWY _____ / _____ / _____

Men B _____ / _____ / _____

Hepatitis B _____ / _____ / _____

_____ / _____ / _____

_____ / _____ / _____

MMR #1 _____ / _____

MMR #2 _____ / _____

Measles, Mumps, Rubella

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

TB _____ / _____ / _____

Other _____

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			Have you been hospitalized?		
Other Diseases	Yes	No	Have you had any surgical operations?		
Alcoholism/Drug Addiction			Are you under medical treatment?		
Anemia			Do you have a physical handicap?		
Anorexia/Bulimia			Are you under care of the State?		
Asthma			Have you been advised to seek psychological help?		
Cancer			Have you received psychological care?		
Chronic Bronchitis			Have you traveled outside the U.S.? Where?		
Chronic Skin Disease (eczema, psoriasis)					
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?		
Hay Fever			Health-Related Behaviors	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:

FAMILY HEALTH HISTORY

Have any relatives (parents, siblings, grandparents) suffered from the following diseases:

<input type="checkbox"/> Asthma _____ <input type="checkbox"/> Abnormal Bleeding _____ <input type="checkbox"/> Arthritis _____ <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Diabetes _____ <input type="checkbox"/> Glaucoma _____ <input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Kidney Disease _____ <input type="checkbox"/> High Blood Pressure _____ <input type="checkbox"/> Mental Disorder _____ <input type="checkbox"/> Migraines _____ <input type="checkbox"/> Seizures _____ <input type="checkbox"/> Thyroid _____ <input type="checkbox"/> Tuberculosis _____	Other history we should know: _____ _____ _____ _____
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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.

Student Signature

Date

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

Date