



# Confidential Sharing Agreement and Consent For Treatment

The college assures that medical information will be regarded as confidential and shared only as necessary for the student's immediate safety. Health Service will not release medical information to parents unless the student signs a separate release of information specific to each illness/incident.

If a serious illness or accident should occur, and there is concern for the student's safety, every effort will be made to contact parents or guardian. However, in the event that delay in medical or surgical treatment may be detrimental to the health of the student, authorization for consultation and treatment by area physicians is requested. Luther College Health Service recognized the importance of cooperating with the student's family physician, clinic, or hospital in providing health care while the student is enrolled in college. In order to secure or exchange health information, it is necessary to have the permission of the student or parent/guardian if the student is under 18. On occasion, information regarding physical or mental health status of a student may be shared with the vice president for student life or counseling staff if there is a concern for the student's immediate safety or the safety of others. No information will be provided to faculty or work study supervisors without specific consent of the student. Due to new federal regulations regarding confidentiality, additional consents regarding health information will need to be signed at the time the student is seen in Health Service.

Permission is hereby granted to share health information with my family physician, clinic, hospital, vice president for student life, or counseling staff if there is a concern for my immediate safety or the safety of others.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/guardian (only needed if student is under age 18)

\_\_\_\_\_  
Date

## HEALTH INSURANCE

Luther College recommends that students be covered by health insurance and carry an insurance card with them. If you do not have insurance coverage, check with insurance companies in your area. If you would like to obtain coverage from a Decorah-area company, visit [www.luther.edu/healthservice/insurance](http://www.luther.edu/healthservice/insurance) for some options. Please make sure your insurance will extend to this area of the country. If you belong to an HMO, be aware of restrictions on medical or pharmaceutical service provided outside your HMO area. Health Service does not direct bill or participate with any insurance companies.

\_\_\_\_\_  
Policy Holder Name

\_\_\_\_\_  
Policy Holder Birthdate

\_\_\_\_\_  
Policy Holder Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
ZIP

\_\_\_\_\_  
Policy Holder Employer

Policy Holder

mother

father

self

other

**ATTACH A COPY of the front and back of your insurance card.**

*Please attach a copy of the front  
of your insurance card here.*

*Please attach a copy of the back  
of your insurance card here.*

## **Tuberculosis Screening**

In compliance with the American College Health Association's guidelines, Luther College requires TB screening and potential TB testing for all students that are identified as high risk. Please complete the Tuberculosis Screening Form and return with the Student Health Evaluation Form.

# Immunizations

Last Name \_\_\_\_\_

Frist Name \_\_\_\_\_

Luther College ID # \_\_\_\_\_

NOTICE: The remainder of this Student Health Evaluation Form requires an appointment with your health care provider. If your health care provider does not have a complete immunization record and you attended school in the United States, you can obtain the records from your school.

TO THE HEALTH CARE PROVIDER: Measles, Mumps, and Rubella – Two doses required for all students born after December 31, 1956 with dose #1 given at age 12 months or later and dose #2 given at least 28 days after first dose. Lab titers can be done for Rubeola if immunity is questioned.

## REQUIRED IMMUNIZATIONS

	month/day/year
<b>MMR</b> #1 <small>(Measles, Mumps, Rubella)</small>	
2 doses required #2	

	month/day/year
<b>DTP</b> #1	
#2	
#3	
#4	
#5	

(Primary Series Dates)

	month/day/year
<b>POLIO</b> #1	
#2	
#3	
#4	

(Primary Series Dates)

	month/day/year
<b>TD or Tdap</b> #1 <small>(within 10 years)</small>	
#2	

Indicate which was received:  TD or  Tdap

	month/day/year
<b>Meningitis Vaccine</b> #1	
#2	

(Menactra, Menveo, Menomune): Administered after 16<sup>th</sup> birthday

## REQUIRED TB SCREENING FOR INTERNATIONAL STUDENTS ONLY (Required Tuberculosis Screening test will be completed at Luther Health Service)

TSPOT: Date collected: \_\_\_\_/\_\_\_\_/\_\_\_\_

Mo. Day Year

Time collected: \_\_\_\_:\_\_\_\_ a.m. p.m.

Hour Min.

Result Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Results:  Positive  Negative

Mo. Day Year

Chest x-ray (if TSPOT positive) Results:  Normal  Abnormal

Date of Chest x-ray \_\_\_\_/\_\_\_\_/\_\_\_\_

Mo. Day Year

## CONSCIENTIOUS/RELIGIOUS EXEMPTION MUST BE NOTARIZED. USE IMMUNIZATION WAIVER FORM FOR NOTARIZATION.

I hereby certify by notarization that my conscientious or religious belief is opposed to immunizations.

\_\_\_\_\_  
Student Signature (or parent or legal guardian if under 18 years of age)

**MEDICAL EXEMPTION**  
Must also complete and include immunization waiver form from our website if unable to meet required immunizations due to medical contraindications. The physical condition of the above-named person is such that immunization would endanger life or health, or is medically contraindicated due to other medical conditions.

\_\_\_\_\_  
Signature of Medical Professional  
Date

## USE IMMUNIZATION WAIVER FORM FOR NOTARIZATION FROM OUR WEBSITE.

**IMPORTANT MESSAGE TO STUDENTS**

Luther College requires that all students have a current health history, physical, and record of immunizations on file in the Student Health Service Office. **Students not in compliance will experience an administrative hold placed on further registration.** It is **mandatory** that you enter your own immunizations online: **Please include an electronic hard copy of your immunizations with this form.** Go to [luther.medicatconnect.com](http://luther.medicatconnect.com). Use the Norsekey sign-on and password that you received from Luther to log in.

## RECOMMENDED IMMUNIZATIONS

		month/day/year	site	manufacturer	lot #	initials	comments/reactions
HEPATITIS B <small>(indicate if twinrix)#2</small>	#1						
	#3						
	#2						
HEPATITIS A	#1						
	#2						
VARICELLA <small>Chicken Pox: Indicate history of or two doses of vaccine#2</small>	#1						
	#2						
INFLUENZA	#1						
	#2						
	#3						
	#4						
HPV	#1						
	#2						
	#3						
TYPHOID	#1						
	#2						
OTHER							

Tuberculin Skin Test: Date Given: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Read: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo. Day Year Mo. Day Year

Interpretation (based on mm of induration as well as risk factors): Induration \_\_\_\_\_ mm  Positive  Negative

Chest x-ray (if above is positive) Results:  Normal  Abnormal Date of chest x-ray: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo. Day Year

# Physical Examination by Health Care Provider

**MUST BE COMPLETED WITHIN 12 MONTHS PRIOR TO COLLEGE ENTRANCE**

Student Name _____	Birthdate _____	Today's date _____
Height _____	Weight _____	Temp. _____
		Pulse _____
		Resp. _____
		BP _____

EXAMINATION	Normal <small>(no mark = not examined)</small>	Abnormal	Abnormal Findings (numbered and noted)	
1. General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	_____	
2. Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____	
3. Head / Face	<input type="checkbox"/>	<input type="checkbox"/>	_____	
4. Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	
5. Ears	<input type="checkbox"/>	<input type="checkbox"/>	_____	
6. Nose & Sinuses	<input type="checkbox"/>	<input type="checkbox"/>	_____	
7. Mouth / Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____	
8. Neck	<input type="checkbox"/>	<input type="checkbox"/>	_____	
9. Thorax	<input type="checkbox"/>	<input type="checkbox"/>	_____	
10. Breasts	<input type="checkbox"/>	<input type="checkbox"/>	_____	
11. Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____	
12. Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____	
13. Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____	
14. Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	_____	
15. Rectal	<input type="checkbox"/>	<input type="checkbox"/>	_____	
16. Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____	
17. Lymphatics	<input type="checkbox"/>	<input type="checkbox"/>	_____	
18. Blood Vessels	<input type="checkbox"/>	<input type="checkbox"/>	_____	
19. Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____	
20. Psychological	<input type="checkbox"/>	<input type="checkbox"/>	_____	
21. Depression	<input type="checkbox"/>	<input type="checkbox"/>	<b>STUDENT ATHLETES ONLY</b> <i>Sickle Cell Trait status</i> <input type="checkbox"/> unknown <input type="checkbox"/> positive <input type="checkbox"/> negative	
22. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>		<b>OPTIONAL</b> Vision Screening _____ Hgb/Hct _____ Cholesterol _____ Urinalysis _____
23. Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>		

I find no medical reason to disqualify \_\_\_\_\_ from participation in athletics.  
Student's Name

If disqualified, please explain: \_\_\_\_\_  
 \_\_\_\_\_

Recommendations for treatment, restriction of academic load or physical activity. Please include period of time for restriction and comments on history.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you this student's usual provider? Yes \_\_\_\_\_ No \_\_\_\_\_

Health Care Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_

Health Care Provider's Name (Printed) \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone number \_\_\_\_\_ FAX number \_\_\_\_\_

*Students: Upon completion of your forms, mail to Health Service, Luther College, 700 College Drive, Decorah, IA 52101.*