Student Health Center
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Spokane, WA 99258-2506
509.313.4066 direct
509.313.5516 fax
studenthealth@gonzaga.edu

GONZAGA UNIVERSITY
HEALTH CENTER

Welcome from all of us at the Gonzaga University Student Health Center!

This packet contains important information about the healthcare services we provide at Gonzaga University as well as some forms for you to fill out so that we can best care for you. Please be sure to return your completed forms to the Student Health Center by August 1.

As you review this information and complete these forms, please let us know if you have any questions.

Sincerely,

Libby Skiles
Director, Student Health Center

New Student Medical Forms

There are a few different medical forms that you will need to fill out and return to the Student Health Center. This information will assist our healthcare professionals in managing any medical illnesses or injuries you may experience while at Gonzaga.

Forms may be returned via the enclosed prepaid envelope, scanned and emailed to studenthealth@gonzaga.edu or faxed to the Student Health Center at (509) 313-5516. **Failure to return these forms by August 1 will impact your ability to register for classes.** The forms include:

1. **Patient Information.** In addition to the information requested on this form, please include a copy (front and back) of your insurance card.
2. **Treatment Authorization for Minors.** If you are going to be under the age of 18 when you arrive at Gonzaga, the Student Health Center requires a parent or guardian to sign the Treatment Authorization section of the Patient Information form.
3. **Health History.** We ask that you complete this form as accurately as possible to let us know of any ongoing health concerns you may have.
4. **Meningitis and HPV Acknowledgement.** Washington State law requires that all students be informed about meningitis and human papillomavirus, including causes, symptoms, and vaccinations.
5. **Immunization History.** Gonzaga requires verification of measles (Rubeola) immunity for all students. Please provide your full immunization history with special attention to the measles requirement.

Healthcare Services and Charges

Our healthcare services are available to all Gonzaga University students, regardless of insurance provider. There is a minimal cost to see our Board Certified Family Medicine Physician or Advanced Registered Nurse Practitioners. Students may pay cash, credit, or charge this amount to their student account. There may be an occasional need for diagnostic tests that cannot be performed in the Student Health Center. We strongly encourage students to have medical insurance to cover these costs.

GONZAGA UNIVERSITY HEALTH CENTER

PATIENT INFORMATION

STUDENT INFORMATION

Name: _____ Date of Birth: _____/_____/ _____

Zag ID#: _____ Sex:_____

Phone: _____ E-mail: _____

Semester and year of enrollment (e.g. Fall 2015): _____

Student Status: ☐ Undergrad ☐ Grad ☐ Law ☐ Doctoral ☐ ESL ☐ International

Will you be participating in: ☐ ROTC ☐ Athletics

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship: _____

Home Phone: _____ Cell phone: _____

Address: _____

HEALTH INSURANCE

The Student Health Center does not bill insurance. We do provide a fee slip that is specifically designed to be submitted to insurance companies for reimbursement of expenses.

As students are responsible for all medical charges incurred with the Student Health Center or any other healthcare providers, **we strongly recommend students have a health insurance plan**. While all students are automatically enrolled in a Student Accidental Injury Insurance Plan, this coverage only extends to accidental injuries.

If you have a health insurance plan in place, notify your provider that your student will be at Gonzaga. If your plan will not cover your student at Gonzaga, consider a supplemental policy.

If you do not have health insurance, review your options at **gonzaga.edu/studentinsurance**.

Insurance company name: _____ ID #: _____

Subscriber's Name: _____ Group #: _____

** Please include a copy (front and back) of your insurance card with this form. **

TREATMENT AUTHORIZATION FOR MINOR STUDENTS

If you will be under 18 when you start at Gonzaga, a parent or guardian must sign the below authorization in order for the Student Health Center to provide care while you are a minor.

I hereby authorize and give my consent to the Student Health Center authorities at Gonzaga University to perform upon or administer to _____ any necessary medical or surgical treatment while attending this University. This authorization does not entitle the Student Health Center to render any treatment without the student's personal consent.

Signature: _____ Date: _____

Relation to student: _____ Phone:_____

Address: _____

GONZAGA UNIVERSITY HEALTH CENTER

PERSONAL AND FAMILY HEALTH HISTORY

STUDENT INFORMATION

Name: _____ Date of Birth: _____ /_____ / _____

Zag ID#: _____ Sex: _____

Please mark (X) in the appropriate space if you or any members of your family have had any of the following:

	You	Family		You	Family
1. Acne/Eczema/Skin Disorder			16. Heart Disease		
2. ADD/ADHD/Learning Disability			17. Hepatitis		
3. Alcohol/Drug Counseling or Treatment			18. High Blood Pressure		
4. Anemia or Blood Condition			19. Immunocompromising Condition/HIV		
5. Arthritis			20. Kidney Disease		
6. Asthma/Lung Disease/Pneumonia			21. Migraines/Frequent/Severe Headaches		
7. Bulimia/Eating Disorder			22. Mobility Limitations		
8. Cancer			23. Mononucleosis		
9. Depression/Anxiety/Psychological Disorder			24. Neurologic Condition		
10. Diabetes			25. Seizure Disorder/Epilepsy		
11. Ear, Nose, or Throat Problems			26. Spinal Injury		
12. Gastrointestinal Disorder			27. Stroke		
13. Gynecologic Problems			28. Thyroid Disorder		
14. Head Injury/Concussion/Loss of Consciousness			29. Tuberculosis		
15. Hearing Loss			30. Vision Impairment		

** If NONE of the above apply, check here: ☐

Explanation for any positive answers (please list by number): _____

_____

_____

Do you have any allergies (medication, food environmental)? ☐ Yes ☐ No

If yes, list and describe reaction:

What medications (over the counter and prescription) do you regularly take?

Are you seeing physician for any medical condition/problem? ☐ Yes ☐ No

If yes, please list condition and physician's name:

Please list types and dates of any hospitalizations and/or surgical operations:

Do you need specific medical assistance (e.g. allergy injections, disability accommodations)? ☐ Yes ☐ No

If yes, please list:

PLEASE READ AND SIGN

I certify that the information above is complete and accurate.

Student Signature: _____ Date: _____

GONZAGA UNIVERSITY HEALTH CENTER

MENINGITIS AND HPV ACKNOWLEDGEMENT

STUDENT INFORMATION

Name: _____ Date of Birth: _____ /_____ / _____

MENINGITIS INFORMATION

Washington State law requires that you be provided with information about the causes, symptoms, and methods of preventing meningococcal disease. As a college student, you need to know about the potentially life-threatening disease caused by meningococcal bacteria.

Meningococcal meningitis affects the brain and spinal cord. It is caused by a group of bacteria that live in the nose and throat. Because it can lead to death within 48 hours, bacterial meningitis requires early diagnosis and treatment. This is often difficult because the symptoms of meningitis closely resemble flu-like symptoms, such as fever, severe headache, neck stiffness, nausea and vomiting, sensitivity to light, and lethargy.

Meningitis is spread through direct contact with infected material, including kissing, coughing, sneezing, or sharing eating or drinking utensils. Studies of outbreaks at colleges and universities suggest that students living in residence halls have a higher risk of contracting this disease because they live and work in close proximity to each other.

A safe vaccine exists that can reduce the risk. Please consult with your doctor or come to the Student Health Center for a vaccination. This vaccination is not required for enrollment at Gonzaga.

HUMAN PAPILLOMAVIRUS (HPV) INFORMATION

Washington State law also requires that we provide information regarding human papillomavirus (HPV) disease and its vaccine.

HPV is a very common virus that is spread through genital contact. There are many types of HPV, and some types can cause cervical cancer or genital warts. Both females and males can get HPV and easily spread it to others without knowing they have it. Most people with HPV have no signs or symptoms.

There is a vaccine that protects against four types of HPV which cause 70 percent of cervical cancers and 90 percent of genital warts.

Please consult with your doctor or come to the Student Health Center for a vaccination. This vaccination is not required for enrollment at Gonzaga.

PLEASE READ AND SIGN

I have read and understand the above information.

Student Signature: _____ Date: _____

GONZAGA UNIVERSITY HEALTH CENTER

IMMUNIZATION HISTORY

STUDENT INFORMATION

Name:_____ Date of Birth: _____ /_____ / _____

Semester and year of enrollment (e.g. Fall 2015): _____

MANDATORY VACCINATION FOR ALL STUDENTS

Gonzaga University requires verification of measles immunity for all students. Proof of immunity means:

1. Two doses of measles (Rubeola) vaccine received after one year of age, at least one month apart, or
2. A blood test showing measles (Rubeola) immunity

You may provide proof of immunity by completing the form below or attaching a copy of your immunization record or blood test (titer) results.

Measles vaccine (may be MMR, MR, or M) #1 _____ /_____ /_____ #2 _____ /_____/_____
Month Day Year Month Day Year

RECOMMENDED VACCINATIONS

Hepatitis A: #1 _____ /_____ /_____ #2 _____/_____/_____
Month Day Year Month Day Year

Hepatitis B: #1 _____ /_____ /_____ #2 _____/_____ /_____ #3 _____ /_____/_____
Month Day Year Month Day Year Month Day Year

HPV (Gardasil): #1_____ /_____ /_____ #2_____ /_____ /_____ #3_____ /_____ /_____
Month Day Year Month Day Year Month Day Year

Meningococcal: #1_____ /_____ /_____
Month Day Year

Polio: Completed primary series of polio immunization? ☐ Yes ☐ No Date of 5th dose _____ /_____ /_____
Month Day Year

Tdap (Tetanus/diphtheria/pertussis): #1 _____ /_____ /_____
Month Day Year

Varicella (Chickenpox): Had disease? ☐ Yes ☐ No #1_____ /_____ /_____ #2_____ /_____ /_____
Month Day Year Month Day Year

Other vaccinations (such as typhoid, yellow fever, etc.):

PLEASE READ AND SIGN

I certify that the information above is complete and accurate.

Student Signature:_____ Date: _____