



DRURY
UNIVERSITY

Welcome to Drury University

This health report is the foundation of your medical record while at Drury. It is filed for reference to be used whenever a consultation for illness takes place. **This health report is not used to determine eligibility for admission.**

Complete medical records enable better health service and health guidance of a student. For this reason, please use care when filling out this form.

1. This completed health form must be on file before a student's registration can be considered complete and before health services are utilized. You will receive your social security number and health insurance information upon your arrival. Students without completed health forms will have a hold placed on the following semester's registration.

2. It is advisable (not required) to have a current eye examination and all necessary dental work completed prior to beginning classes.

3. Drury University health service is provided and supervised by Cox Health Systems and is available to full-time day students who have completed and submitted the health report. The costs of Health Center visits, as well as referred visits to the Family Medical Care Center at Cox, are covered through the health fee each full-time student pays to the university. Lab fees, X-rays and other procedures are the financial responsibility of the student.

4. The Health Center is staffed by a R.N. who is able to examine the student, discuss concerns, offer over the counter medicines for common ailments, provide routine immunizations (not allergy injections) and make medical referrals as needed. The Health Center, located in Findlay Student Center, is open daily when classes are in session. The Health Center is not open Saturday, Sunday or holidays. Weekend or after-hours emergency care is available nearby and is the student's financial responsibility.

5. The student's immunization history may be obtained from records at: physician's office, high school, baby book, military or health department records.

6. Information about immunizations, including the meningococcal vaccine, may be found at the web address of: <http://www.cdc.gov/nip/recs/teen-schedule.htm#chart>.

7. If the student is from outside the Springfield area, please call your insurance providers' 800 number. Ask if this provider has a preferred provider while in the Springfield area, either Cox or St. Johns. This will help us direct you to the appropriate caregivers if urgent care or extensive testing is needed. Also a front/back copy of your insurance card for the student is a good idea.

Supplemental student insurance plans are obtainable at lower costs, if needed. More information about one plan may be viewed at: www.ejsmith.com. **Students must show documentation of health insurance coverage prior to admission.** See general catalog for further information.



Drury University Office Use Only

Reviewed by _____

Date reviewed ____/____/____ Date completed ____/____/____

Comments _____

Date deficiency notice(s) Sent ____/____/____

Confidential Health Report

Name _____
Last (family name) First (given) Middle

HEALTH CARE PERMIT (if student is under 18 years of age at time of enrollment – PLEASE READ)

I consent and give my permission for my child/ward to receive medical or surgical care deemed appropriate and advisable by Student Health or the Counseling Service or by a physician, health care worker or hospital selected by the Student Health or Counseling Service. I understand that, except in an emergency, no surgical operation (other than a minor office procedure) will be performed on my minor child/ward without my being contacted and fully informed.

Date _____ Signature Relationship to Student _____

Return this completed application to:

Drury University
Student Health Office
900 North Benton Avenue
Springfield, Missouri 65802

Phone: 417-873-7218
Fax: 417-873-7533
www.drury.edu

Address _____
Number and Street

City or Town State Country Zip code (Postal code)

Age _____ Date of birth _____ Home Phone _____
Month/day/year

Social Security Number _____

Name of parent guardian spouse _____

Address (if different from students') _____
Number and Street

City or Town State Country Zip code (Postal code)

Phone number/s of parent/guardian/spouse _____

Health insurance provider _____

Policy number _____ Phone number _____

If insurance provider is from outside Springfield area, call to determine if preferred provider is

Cox or St. Johns (circle)

(This will help expedite the most cost-effective health care for your student if Urgent Care is needed.)

Primary physician _____ Phone number _____

Dental provider _____ Phone number _____

Confidential Health Report

Information, including the obtaining of any required immunizations, must be supplied for registration to be complete. Registration will be blocked for the following semester if this information is not completed.

Have you or any of your blood related family members had?

- | | | | | |
|-----------------------------|------------------------------|-------------------------------|--------------------|------------|
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Cancer | Relationship _____ | type _____ |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | High blood pressure | Relationship _____ | |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Bleeding disorder | Relationship _____ | |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Tuberculosis | Relationship _____ | |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Diabetes | Relationship _____ | |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Kidney disease | Relationship _____ | |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Heart disease | Relationship _____ | |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Arthritis | Relationship _____ | |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Gastrointestinal disorder | Relationship _____ | |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | History of drug/alcohol abuse | Relationship _____ | |

Personal History: Answer all questions related to your past health history. Comment on all Yes answers below.

- | | | | | | |
|-----------------------------|------------------------------|--|-----------------------------|------------------------------|------------------------------------|
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Recurrent colds or chronic cough | <input type="checkbox"/> NO | <input type="checkbox"/> YES | Disease or injury of bones/joints |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Chronic skin disease eczema or psoriasis | <input type="checkbox"/> NO | <input type="checkbox"/> YES | Recurrent diarrhea or constipation |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Asthma or hay fever | <input type="checkbox"/> NO | <input type="checkbox"/> YES | Back problems |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Malaria | <input type="checkbox"/> NO | <input type="checkbox"/> YES | Frequent Urination |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Sinusitis | <input type="checkbox"/> NO | <input type="checkbox"/> YES | Eye Problems |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Seizure disorder/Epilepsy | <input type="checkbox"/> NO | <input type="checkbox"/> YES | Head injury |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Ear/nose/throat problems | <input type="checkbox"/> NO | <input type="checkbox"/> YES | Recurrent or severe headache |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | High or low blood pressure | <input type="checkbox"/> NO | <input type="checkbox"/> YES | Sexually Transmitted Infection |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Eating disorder | <input type="checkbox"/> NO | <input type="checkbox"/> YES | Worry/Nervousness |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Rheumatic fever | <input type="checkbox"/> NO | <input type="checkbox"/> YES | Chicken Pox |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Dizzy/Fainting | <input type="checkbox"/> NO | <input type="checkbox"/> YES | Heart mummer |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Rubella measles | <input type="checkbox"/> NO | <input type="checkbox"/> YES | Insomnia |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Hepatitis | <input type="checkbox"/> NO | <input type="checkbox"/> YES | Rubeola measles |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Frequent Anxiety | <input type="checkbox"/> NO | <input type="checkbox"/> YES | Surgeries/Hospitalizations |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Mumps | <input type="checkbox"/> NO | <input type="checkbox"/> YES | Severe injuries/accidents |
- Females only:**
- NO YES Heavy flow
- NO YES Irregular Periods
- NO YES Severe Cramps

Comment on all "YES" answers. _____

List all medications you currently take: _____

List all allergies including medicines, foods, insect stings: _____

Do you:

Smoke Drink alcohol Use drugs Use contraception Use seat belts Wear sunscreen

Physical examination (recommended)

It is **required** for intercollegiate sports participants.

A physical examination by a health care provider **is not required, but is encouraged** to promote good health habits.

Height _____ Weight _____ BP _____ Pulse _____ Temp _____ Resp _____

	WNL	Abnormal
Head, Ears, Nose or Throat _____		
Eyes (w/ophthalmoscope) _____		
Neck, Thyroid _____		
Respiratory _____		
Cardiovascular _____		
Gastrointestinal _____		
Hernia _____		
Genitourinary _____		
Musculoskeletal _____		
Metabolic/Endocrine _____		
Neuropsychiatric _____		
Skin _____		

Comments: _____

Student may participate in intercollegiate and/or intramural sports

Physician's signature _____ Date _____

TB Self Screening – REQUIRED

1. Can you answer yes to any of the following? NO YES
 - a. Have you ever lived with or been in close contact with anyone who had TB disease?
 - b. Have you ever had a positive HIV test?
 - c. Have you ever used illegal intravenous drugs?
 - d. Have you ever been incarcerated (jail)?
 - e. Have you ever been homeless?
 - f. Have you ever been told you had a positive TB skin test?
2. Do you currently have any of the following symptoms that are unexplained and have lasted at least 3 weeks? NO YES

Cough, Fever, Night Sweats, Weight loss
3. Were you born outside the US? **OR** Have you lived outside the US within the past 5 years **OR** Have you visited outside the US for 1 month or longer to any country **EXCEPT**: Canada, Jamaica, St. Kitts, Nevis, Saint Lucia, Virgin Islands, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marion, Sweden, Switzerland, United Kingdom, American Samoa, Australia, New Zealand. NO YES

If yes, what country? _____

Confidential Health Report

Did you answer YES to any question in #1 - #3? NO YES

If NO please proceed to Required Immunizations. No further TB information is needed.

If YES, you will need to have a health care provider complete the remaining TB information.

If yes, a TB skin test is REQUIRED or documentation of having received a PPD that was read as a positive reaction per the CDC or ACHA definition of positive; which includes risk factors, size of reaction and previous BCG vaccination. This should be followed by a negative chest x-ray. The Mantoux test (PPD) must be applied and read within 48-72 hours of application. Testing is still required even with prior BCG vaccination. A negative chest x-ray is not a substitute for a skin test.

www.cdc.gov/nchstp/tb/pubs/corecurr/ or www.acha.org/info_resources/tb_statement.pdf

If you answered yes this must be filled out by a health care provider

Mantoux test (PPD) Date given ____/____/____ Date read ____/____/____

Results read in mm of induration (bump), if no induration write 0. _____mm.

(PPD must be given within 3-6 months of the beginning of classes at Drury University. This may be obtained at Drury Student health for a small fee.)

A chest x-ray is required if PPD is read as positive per CDC/ACHA definition of positive (see above). Please include interpretation of x-ray or enclose copy of report.

Date of chest x-ray ____/____/____

Interpretation of x-ray _____

Treatment if needed _____

I certify that this student is free from active TB or is currently being treated and does not pose a risk to the Drury University community.

Signature of health care provider

phone number

date

Required Immunizations:

1. Date of completion of primary DPT series ____/____/____

Date of Current TD (within 10 years) ____/____/____

2. Date of completion of primary polio series ____/____/____

3. Dates of 2 MMR's at least 1 month apart, AND after 12 months of age except for those born prior to 1957 who are considered to have immunity to measles.

#1 ____/____/____ #2 ____/____/____

Recommended Immunizations and date given:

Hepatitis B #1 ____/____/____ #2 ____/____/____ #3 ____/____/____

Hepatitis A #1 ____/____/____ #2 ____/____/____

Varicella (chicken pox) #1 ____/____/____ #2 (if older than 13) ____/____/____

Meningococcal vaccine ____/____/____ HIB ____/____/____

Other _____

All statements above are true to my knowledge, and I have no health problems or medical restrictions not mentioned in this record.

Student Signature (If student is under 18 – parents signature required)

Date