

DATE _____

RETURN TO: BRIAR CLIFF UNIVERSITY HEALTH OFFICE • 3303 REBECCA STREET, SIOUX CITY, IA 51104 • 712-279-5436

CHECK APPROPRIATE BOXES International Transfer Athlete - Sport _____

NURSING PROGRAM Basic Program RN-BSN Program LPN-BSN Program Other Program

Name (LAST) _____ (FIRST) _____ (M.I.) _____ Male Female

Date of Birth _____ SSN# _____ Entering as a (circle one): FR SO JR SR GRAD

Home Address _____ City _____ State _____

Resident Status (CHECK ONE) Residence Hall Alverno Baxter Noonan Toller Room # _____ Commuter

Commuter Address _____ Home Phone (_____) _____

Email Address _____ Cell Phone (_____) _____

Emergency Contact's Name _____ Home Phone (_____) _____

Contact's Address _____ Cell Phone (_____) _____

PARENTAL CONSENT FOR EMERGENCY CARE FOR STUDENTS UNDER 18 YEARS OF AGE

In case of an accident or emergency where there is not time to contact the parents, the University is hereby given authority to make decisions for treatment or surgery.

Parent(s) or Guardian(s) (circle one) Signature: _____

FAMILY HISTORY

	Name	Age	State of Health	Occupation	Age/Cause of Death
Father					
Mother					
Brother(s)	NA				
Sister(s)	NA				

What relative has had:

Diabetes _____ Kidney Disease _____ Cancer _____
 Asthma, Hay Fever _____ Heart Disease _____ Mental Illness _____
 High Blood Pressure _____ Seizures, Convulsions _____ Tuberculosis _____

PERSONAL HISTORY (Please answer all questions.)

Have you had . . .	Yes	No		Yes	No		Yes	No		Yes	No
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Back Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Weakness/Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Bone Fractures	<input type="checkbox"/>	<input type="checkbox"/>
German Measles	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Gum/Tooth Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Joint Disease/Injury	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, Cyst	<input type="checkbox"/>	<input type="checkbox"/>	Ear Eye Nose Throat	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Skin Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	High or Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Surgery (describe below)	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever/Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Problems	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	with Unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Urinary Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Smoker	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>							Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "yes" responses _____

ALLERGIES: Describe known allergies or drug sensitivities _____

MEDICATION: Prescription, over the counter, supplements, or performance agents you are taking _____

Have you had any illness or surgery which required hospitalization? YES NO EXPLAIN _____

Have you consulted or been treated by clinic, physician, or other practitioners within the past five years? YES NO EXPLAIN _____

If so, have any of your activities been restricted in the past five years? YES NO EXPLAIN _____

IMMUNIZATION INFORMATION *** Refer to Immunization policy in the student handbook.

- All freshman & transfer students are required to attach a copy of immunization records – please make sure the student's name is on the copy.
- If you received any immunizations while attending BCU, please submit a copy to the Health Office.

STATE LAW REQUIRES the following information be submitted for those living in the residence halls.

Meningococcal immunization (Circle one) **NO YES** DATE RECEIVED ____/____/____

Have you received information on meningococcal disease and benefits of the vaccine (Circle one) **YES NO**

• I acknowledge that Briar Cliff University abides by the **Protected Health Information Privacy Act.**

(A copy of the Protected Health Information Act is available in the Health Office.) A signature is required prior to the release of any health information. I hereby authorize Briar Cliff University to release verbally or by documentation from the medical record:

- Briar Cliff University Athletic Department (a computerized copy of the Medical History Form is available for the trainer)
- Briar Cliff University Nursing Department (a computerized copy of the Medical History Form is available for the Dept. of Nursing)
- (Names) of my parents and/or guardian _____

I may withdraw this consent at any time by providing written notice, except that disclosure made is good faith, in reliance on this consent, has already occurred. I hereby authorize the release of information as indicated above.

STUDENT SIGNATURE REQUIRED

PRINT NAME _____ SIGNATURE _____

DATE _____

PHYSICAL EXAM; Recommended for all students • Required for athletes & nursing students

No chiropractor examination will be accepted for nursing.

HEIGHT _____ WEIGHT _____ PULSE _____ BLOOD PRESSURE _____

Lab Work (If desired by physician.)

Urine:Glucose _____ Protein _____ Blood _____ Other _____

Are there any abnormalities of the following systems?

	Yes	No	Please use this area to describe any positive findings.
Head, Ears, Nose, or Throat	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	
Metabolic/Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	
Neuropsychiatric	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	

Is there loss or seriously impaired function of any paired organ? Yes No

Recommendation for physical activity (PE, Athletics, Intramurals) Unlimited Limited

If limited, please explain _____

Is the patient now under treatment or medication for any medical or emotional condition? Yes No

If yes, please explain _____

PRIMARY CARE PROVIDER (PRINT) _____

PCP SIGNATURE _____ **DATE** _____

Address _____

Phone Number _____