

RETURN COMPLETED FORM to ChargerHealth@briarcliff.edu

OR Mail to Briar Cliff University Health Office • 3303 Rebecca Street, Sioux City, IA 51104 • 712-279-5436

CHECK ALL APPROPRIATE BOXES Athlete-Sport _____ International Transfer
 Doctor of Physical Therapy Nursing Program

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

Date of Birth _____ / _____ / _____ Entering as a (circle one): FR SO JR SR GRAD Male Female Other _____
MONTH DAY YEAR

Home Address _____ City _____ State _____

Resident Status (CHECK ONE) Residence Hall Alverno Baxter Noonan Room # _____ If room is not assigned, leave blank

Living Off Campus - Local Address _____

Cell/Home Phone (____) _____ Email Address _____

Emergency Contact's Name _____ Cell/Home Phone (____) _____

PERSONAL HISTORY (Please answer all questions.)

Have you had . . .	Yes	No		Yes	No		Yes	No		Yes	No
Measles	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Weakness/Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<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"/>	Other Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, Cyst	<input type="checkbox"/>	<input type="checkbox"/>	Ear Issues	<input type="checkbox"/>	<input type="checkbox"/>	Joint Disease/Injury	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Eye Issues	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis*	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Surgery (list below)	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Long COVID Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	Reflux/GERD	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Issues	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Issues	<input type="checkbox"/>	<input type="checkbox"/>	ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury with Unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>	Back Issue/Pain	<input type="checkbox"/>	<input type="checkbox"/>	Other Emotional Problems	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clot	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Bone Fractures	<input type="checkbox"/>	<input type="checkbox"/>	Smoker/Vaper	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Genital/Urinary Issues	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>
						Intestinal/Bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>	Suicide Attempt	<input type="checkbox"/>	<input type="checkbox"/>

***ALL** international students must complete **tuberculosis screening form**. Tuberculosis skin or blood test may be required prior to arrival on campus.

If you answered yes to any questions above, please explain: _____

ALLERGIES No Yes: List known allergies (environmental or medical) or drug sensitivities _____

Has the known allergy required emergency medications or treatment? No Yes **Explain** _____

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 _____

Current Health Care Physician or Clinic Name _____ Phone _____

IMMUNIZATION INFORMATION

BCU REQUIRES THAT OFFICIAL IMMUNIZATION RECORDS BE SUBMITTED to ChargerHealth@briarcliff.edu BY AUGUST 1 OR MOVE-IN DATE FOR THOSE ATTENDING IN PERSON CLASSES, PARTICIPATING IN ATHLETICS, AND LIVING IN THE RESIDENCE HALLS

Required Immunizations:

- MMR (measles, mumps, rubella) 2 doses after the 1st birthday and at least 30 days apart OR Positive Measles (rubeola) IgG antibody titer
- Meningitis (ACWY) 1 dose given after age 16 (applies to all students 21 and under)
- Tdap (tetanus, pertussis) 1 adult dose
- Polio-primary series completed
- Varicella (chicken pox)-2 doses OR verification of disease OR positive Varicella IgG antibody titer

ALL HEALTH REQUIREMENTS MUST BE REVIEWED BY THE HEALTH OFFICE BEFORE MOVING TO CAMPUS, PARTICIPATING ON SPORTS TEAMS, OR ATTENDING CLASS! PLEASE ALLOW 5-7 DAYS FOR APPROVAL.

*****Refer to [Student Health Requirements \(click here\)](#)**

Please check option used to submit immunization record:

- Attached Faxed to [Attn:Nurse at 712-279-5426](mailto:Attn:Nurse@712-279-5426) Emailed to Campus Nurse at ChargerHealth@briarcliff.edu
 Mailed to Health Office, 3303 Rebecca Street, Sioux City, IA 51104

Iowa law requires that colleges with on-campus housing must educate incoming students on Meningococcal Disease and vaccination. Meningitis is a rare but serious infection of the lining of the brain caused by bacteria or a virus. Bacterial meningitis is highly contagious and can be fatal or result in serious long-term effects such as blindness, coma, amputations, and permanent brain damage. College students are at a higher risk of contracting the disease due to living in close quarters and interactions. The CDC recommends college students receive the Meningitis (ACWY) vaccine offering protection against life-threatening meningococcal disease.

I have read the above information on meningococcal disease and benefits of the vaccine and understand I should consult my physician if I have any further questions or concerns.

Initial: _____

Not immunized ([Exemptions are available. Acknowledgment of risk form must be completed and on file in the health office. Requests can be made by contacting the nurse at \[chargerhealth@briarcliff.edu\]\(mailto:chargerhealth@briarcliff.edu\)](#))

I acknowledge that Briar Cliff University abides by the [Protected Health Information Privacy Act](#).

(A copy of the BCU HEALTH OFFICE NOTICE OF PRIVACY PRACTICES 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 (athletic trainer/coach)
 Briar Cliff University Nursing Department (Med. Director)
 Briar Cliff University Counseling Office (counselor)
 (Names) of my parents and/or guardian _____

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

Student Signature

Date

EMERGENCY TREATMENT CONSENT: In case of an accident or emergency in which I may be unable to direct my own medical care, I authorize Briar Cliff University to seek appropriate care for me until those identified as emergency contact persons can be notified.

I hereby state that the above information is true and I give permission for Briar Cliff University Health Services to release information to health care providers and facilities who are included in my treatment.

If under 18, must be signed by both student and parent and/or guardian.

Student Signature

Parent/Guardian Signature

Date

ELECTRONIC FORM ONLY: I understand that by typing my name here, I am signing this form electronically.

Form must be completed in it's entirety. If any questions, signatures, or dates are left blank, you will be contacted. Thank you!

FOR HEALTH OFFICE USE ONLY: Received _____ Approved _____ Pending _____