



Welcome to Coe College!

Coe College Health Services is here to support you during your time at Coe! You are about to embark on an exciting journey over the next few years, and we want you to know that we are here for your health and wellness needs! If you have a special request, or require assistance with a medical problem, please contact us at 319-399-8617 or by email: o-healthservices@coe.edu.

Coe College Health Services is a campus health clinic that provides primary medical care, acute illness and chronic disease management, women's health and mental health services, as well as wellness, sexual health, nutrition, and certain immunizations. Our clinic is staffed by a full-time Registered Nurse and a part-time Nurse Practitioner. We are an appointment-based clinic, and we are located below the PUB, across from Gage Union. Students enrolled at Coe College are automatically assessed a health services fee in their tuition cost, which entitles them to many services at no cost. Any charges that are incurred for prescriptions, immunizations, lab tests, X-ray, or referrals to other clinics and/or the ER, will require that you submit your personal health insurance or pay for the costs incurred.

Coe College requires that all students have a current health history, physical (within the last 12 months), health insurance information, and immunizations on file in the Health Services clinic. These forms are confidential and are used by the Health Services team to provide the best possible healthcare to you. (If you will be participating in Coe Athletics, please refer to their requirements for physical and forms they need, in addition to submitting the above forms to Health Services.)

An important action for you to take now is to download and print the health forms from the Coe College website (<http://www.coe.edu/uploads/pdfs/campuslife/healthservices/mandatory-health-forms.pdf>). The physical and immunization forms need to be filled out by your health care provider. Please take time to review your immunization history and make sure you have received the required and recommended vaccinations before you arrive on campus. (<http://www.coe.edu/campuslife/healthservices/prematriculation>) You will not be allowed to register for subsequent semesters if we do not have your immunization records. Check with your health care provider, health department, or your high school for these records. Submit the records by email, fax or mail to Health Services before the start of classes.

Please complete and submit all five health forms by July 1 to:

Coe College Health Services
1220 First Ave NE
Cedar Rapids, IA 52402

Forms can also be emailed to o-healthservices@coe.edu or faxed to 319-399-8269

Thank you and we look forward to meeting you soon! Go Kohawks!
Sara Heisdorffer, BSN, RN, Health Coordinator

New Student Health Services Checklist: due by July 1st:

- Medical History and Insurance form:** to be completed by the student. Please verify that your health insurance coverage is valid in Cedar Rapids while you are a student at Coe.
- Physical Exam:** to be completed by your Healthcare provider w/in the last 12 months prior to classes starting (athletes need physical w/in the last 6 months)
- Tuberculosis screening form:** required for all students, domestic and international.
- Immunization records:** note required and recommended vaccines
- Minor students:** please make sure your parent/legal guardian signs forms where appropriate.

Coe makes it possible. You make it happen.



COE COLLEGE

HEALTH SERVICES

Medical History and Insurance Form

This form is to be completed by the student. Please provide any information about chronic illness, health problems, medication allergies or disabilities. All of the information given to Health Services is confidential and will not be released to any other department without your knowledge and consent. Return form to: **Coe College Health Services by JULY 1st** 1220 First Ave. NE, Cedar Rapids, IA 52402
Phone: 319-399-8617 Fax: 319-399-8269. Forms may be scanned and emailed to: o-healthservices@coe.edu

Student Information

Last Name	First Name	Middle	Birth Date
Preferred Name (if different from given name)			
Home Address	City	State	Zip
Student Cell Phone (with area code)	Social Security Number		
Notify in Emergency:			
Parent/Guardian	Home Phone		
Address	City	State	Zip
Phone number	Alternate phone number		

Health Insurance Information

It is strongly recommended that students have health insurance that provides them coverage in Cedar Rapids, IA. The Affordable Care Act allows students to stay on their parents' policy through age 26. Some insurance companies also require that "Care Away From Home" is established prior to the student coming to College. **Do you have health coverage under a family or individual policy? (please circle) Yes / No**

Health Insurance Company Name	Name of Policy Holder	
Policy Holder's Name	Policy Holder's Birthdate	SSN of Policy Holder

You MUST carry a copy of your medical insurance card. This information will be needed should you require health care outside of Coe Health Services or to obtain prescribed medication at the pharmacy.

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.

Consent for treatment: (to be signed by student; if student is a minor, parent/legal guardian signature also required):

I authorize the nurse practitioner at Coe College Health Services and/or its representative (for example, UnityPoint or Mercy providers) to treat me in case of medical need, including emergency or surgical care that is considered necessary, while a student at Coe College.

Student: _____ **Date:** _____ **Parent:** _____

Coe makes it possible. You make it happen.



Last Name _____

First Name _____

Student Coe ID Number _____

Family Medical History

	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Sibling					
Sibling					
Sibling					

Have any of your relatives (parent/grandparent/sibling) had/have?

	Yes	No	Relationship
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sickle Cell Trait	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma/Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Health Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____

Student Medical History

Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Ear, Nose, Throat Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Headache/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury/Concussion	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	If you've had a concussion, how many? _____		
Urinary Tract Infections	<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Irregularity	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Genetic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Female/Age of Menstruation _____		
Sickle Cell Trait	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>			
Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Disease or Injury of Joints	<input type="checkbox"/>	<input type="checkbox"/>			
Surgery (describe below)	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>			
Do you use drugs?	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>

Comment on all positive answers, include dates, below:

I have this "Med-Alert" condition: _____

On-going chronic illness: _____

List medication allergies: _____

List other allergies: _____

Do you have physical or learning disabilities? _____

Are you taking any medications regularly? _____

Do you consider your weight to be healthy? _____

Have you traveled outside of your native country in the past 12 months? If so where _____

Coe makes it possible. You make it happen.



COE COLLEGE

HEALTH SERVICES

Physical Examination Form

This form must be submitted by **July 1st** to Coe College Health Services
Forms may be scanned and emailed to o-healthservices@coe.edu

It is recommended that all students have a physical exam on file, in order to receive the best possible health care, while at Coe College. The physical exam must be completed by your health care provider within the past 12 months. Student Athletes must have a physical within the past 6 months. Student Athletes must complete health record requirements for Health Services and Athletics.

Student's Name _____ Birth Date _____ Gender: Male _____ Female _____
 Temp _____ Height _____ Weight _____ Heart Rate/Pulse _____ RR _____ BP _____ / _____
 Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____
 Hearing: R _____ L _____ Dental Care Needed: Y N Hgb/Hct (if indicated) _____

Exam	Normal	Abnormal	
(please check normal or abnormal. No mark= no exam)			
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"/>	_____
22. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____
23. Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____

24. Student Athlete's **only**—Sickle Cell trait status: unknown positive negative

• Any allergies? _____

• Current medications: _____

• Is the student currently being treated for an emotional disorder? If Yes please explain: _____

• Recommendations for treatment, restriction of academic load or physical activity. Please indicate period of time for restriction and comments on history: _____

Are you this student's regular healthcare provider? Yes _____ No _____

Name (print) _____ Signature _____ Date _____

Phone _____ Fax _____

Address _____ City _____ State _____ Zip _____

CLEARANCE FOR ATHLETICS: Only to be completed if student will participate in Coe Athletics

_____ Cleared

_____ Cleared after completing evaluation/rehabilitation for: _____

_____ Not Cleared for: _____ Reason: _____

By signature, I authorize Coe Health Services to release a copy of my health history and physical to the Athletic Department, Nursing Department, and/or Accessibility Department at Coe College (as applicable).

Student Signature _____ Date _____

Coe makes it possible. You make it happen.



Tuberculosis (TB) Screening Form

(To be completed by the student)

Note: The tuberculin skin test needs to be read by a healthcare professional in 48-72 hours. If you are unable to return to the clinic in 48-72 hours, you should delay this test until a return visit is possible within this timeframe. If you are an international or health sciences student and choose to do the PPD skin test, a 2-step process is required, meaning one skin test placed, read at 48-72 hours, followed by a second skin test placed at least one week later, and then read at 48-72 hours.

Name _____

Date _____

Please indicate the following:

Yes No

- | | | |
|--|-------|-------|
| 1. I have been in close contact with someone who has active tuberculosis. | _____ | _____ |
| 2. I am foreign-born from, or have traveled to an endemic region (Africa, Asia, Russia, Eastern Europe, Central or South America). | _____ | _____ |
| 3. I have been a resident or employee of high-risk congregate settings (ie. Correctional facilities, long-term care facilities, homeless shelters) | _____ | _____ |
| 4. I am a health care worker (ie. Nursing or athletic training student). | _____ | _____ |
| 5. I have had BCG vaccine (if yes, IGRA blood test recommended instead of PPD skin test). | _____ | _____ |

If you answered YES to any of the above questions, Coe College requires that you receive TB testing as soon as possible.

If you answered NO to the above questions, no further testing or action is needed.

Are you presently experiencing any of the following symptoms?

- | | | |
|------------------------------------|-------|-------|
| 1. Fever | _____ | _____ |
| 2. Night sweats | _____ | _____ |
| 3. Cough lasting 3 weeks or longer | _____ | _____ |
| 4. Coughing up blood | _____ | _____ |
| 5. Chest pain | _____ | _____ |
| 6. Unexplained weight loss | _____ | _____ |
| 7. Unusual fatigue | _____ | _____ |

Medications you are taking _____

Allergies to medication _____

Student's signature _____

Coe makes it possible. You make it happen.



COE COLLEGE

HEALTH SERVICES

Immunizations

Coe College requires proof of immunizations on file in Health Services prior to class registration. This information must be submitted by **JULY 1st** to Coe College Health Services. The documents may be scanned and emailed to o-healthservices@coe.edu. Student registration is held until proof of immunizations has been submitted to Health Services at Coe College.

Last Name	First Name	Middle	Birth Date
-----------	------------	--------	------------

REQUIRED IMMUNIZATIONS

DTP (Primary Series Dates) (Td or Dtap)	#1 _____ #2 _____ #3 _____ #4 _____	Polio (3 Dose Primary Series and Booster)	#1 _____ #2 _____ #3 _____ #4 _____	MMR (Measles, Mumps, Rubella) 2 doses required	#1 _____ #2 _____
--	--	--	--	---	----------------------

TD or Tdap (indicate Td, or Tdap) #1 _____ #2 _____
Diphtheria/Tetanus/Pertussis (within 10 years) Booster Series. Two doses required.

RECOMMENDED IMMUNIZATIONS

****Meningococcal (Highly Recommended)** MenACWY _____ and MenB _____ Date _____

Hepatitis B Series (Required for Nursing and Athletic Training)	#1 _____ #2 _____ #3 _____	Hepatitis A	#1 _____ #2 _____	Varicella - Date of chicken pox:	_____
				<i>(Indicate history of chicken pox or 2 doses of vaccine)</i>	#1 _____ #2 _____

HPV #1 _____ #2 _____ #3 _____

Influenza #1 _____ #2 _____ #3 _____ #4 _____

Other _____

Healthcare Professional Signature _____ **Date** _____

INTERNATIONAL STUDENTS – PLEASE COMPLETE THIS PORTION

- DO NOT HAVE A TUBERCULOSIS SKIN OR BLOOD TEST DONE PRIOR TO COMING TO COE COLLEGE. TB SCREENING MUST BE DONE IN THE UNITED STATES.
- Do not have a BCG vaccination prior to coming to Coe College.
- If you are required to have a chest x-ray, it must be done in the United States within 3 months of starting at Coe College.
- If you have been treated for TB infection or disease, bring a copy of your treatment report written in English.

If you have had a positive reaction to a tuberculin skin test (Mantoux 5 TU/PPD), that is, swelling greater than or equal to 10mm as read within 48-72 hours of being tested, bring documentation validated by the signature and stamp/seal of an authorized immunization official.

For positive TST test result individuals only: TST given-date: ____/____/____ TST read-date: ____/____/____ Reaction in mm: _____
month day year month day year

Do you have a history of BCG vaccinations? No Yes - date of most recent BCG: ____/____/____
month day year

cdc.gov/tb and who.int/tb/en/

Meningitis Vaccine Information

Meningococcal disease is a potentially life-threatening bacterial infection caused by Neisseria meningitides, a leading cause of bacterial meningitis in older children and young adults in the United States. The disease most commonly is expressed as either meningococcal meningitis, an inflammation of the membranes surrounding the brain and spinal cord, or meningococemia, a serious infection of the blood. Since 1991, cases of meningococcal disease among 15-24 year olds have increased. Studies show that students residing in on campus dormitories, especially first-year students, appear to be at up to a six-fold increase risk for meningococcal disease than other college students overall. Vaccinations are available against five of the most common strains of N.meningitidis in the United States. Iowa law requires that we provide this information on Meningitis and the vaccine. MCV4 or MPSV4, which protects against serogroups A, C, W or Y, is given to preteens and teens beginning at age 11-12 years. A second dose is needed at age 16. Teens and young adults age 16-23 may also be given MenB which is a vaccine for preteens against meningococcal serogroup B disease. Please talk to your health care provider about these vaccines. **I am aware that if I had this vaccine prior to age 16, a booster is indicated.**

- I have received the meningococcal vaccine. (See above)
- I decline the vaccination

Your signature verifies that you have read this information: Signature: _____ Date _____

Immunization Exemption for medical or religious reasons:

MEDICAL EXEMPTION - Separate documentation signed by a medical professional must be provided

CONSCIENTIOUS/RELIGIOUS EXEMPTION - separate notarize documentation must be provided.

The form may be found at coe.edu under the Health Services tab

Coe makes it possible. You make it happen.