



# COE COLLEGE

## HEALTH SERVICES

Welcome to Coe College!

Coe 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 any questions, please contact us at 319-399-8617 or by email: [o-healthservices@coe.edu](mailto:o-healthservices@coe.edu)

Coe Health Services is a campus health clinic that provides short term health care, acute illness management, medical referrals, wellness information, sexual health, and seasonal influenza vaccinations. Our clinic is staffed by a full time Registered Nurse and a part-time Nurse Practitioner. We are an appointment-based clinic, located below the PUB, across from Gage Union. Students enrolled at Coe College are assessed a health services fee, which helps provide many health and wellness resources. Any charges that are incurred off-campus 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 associated.

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. If you are participating in the NCAA athletics at Coe, you will need a physical completed within the last 6 months. Be sure to submit all required information to both Athletics and Health Services. All patient information is kept confidential and used by the Health Services team to provide the best possible care.

Health forms are located on the Coe College website (<http://www.coe.edu/student-life-resources/health-services-1/healthforms>).

The physical and immunization forms should be completed 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. **YOU WILL NOT BE ALLOWED TO REGISTER FOR SUBSEQUENT SEMESTERS IF WE DO NOT HAVE YOUR COMPLETE IMMUNIZATION RECORD ON FILE** (<http://www.coe.edu/campuslife/healthservices/prematriculation>).

Check with your health care provider, health department, or your high school for these records.

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](mailto:o-healthservices@coe.edu) or faxed to 319-399-8269

Thank you and we look forward to meeting you soon! Go Kohawks!  
Julie Mueller, BSN, RN, Assistant Director of Health Services Coe College

### New Student Health Services Checklist: due by July 1<sup>st</sup>:

- 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.

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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 Health Service July 1<sup>st</sup>**. Address: 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](mailto: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		
<b>Notify in Emergency:</b>			
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	Policy Holder / Member Name (Employee)
Individual or Dependent Covered	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:** \_\_\_\_\_

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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 \_\_\_\_\_

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HEALTH SERVICES

## Physical Examination Form

This form must be submitted to Coe Health Services **by July 1st**  
Forms may be scanned and emailed to [o-healthservices@coe.edu](mailto: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 <input type="checkbox"/> positive <input type="checkbox"/> negative <input type="checkbox"/> (found within patient's newborn screening results)

• 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 \_\_\_\_\_

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## 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 \_\_\_\_\_

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# 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 to Health Services by July 1<sup>st</sup>. The documents may be scanned and emailed to [o-healthservices@coe.edu](mailto: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
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### REQUIRED IMMUNIZATIONS

<b>DTP (Primary Series Dates)</b> (Td or Dtap)	#1 _____ #2 _____ #3 _____ #4 _____	<b>Polio</b> (3 Dose Primary Series and Booster)	#1 _____ #2 _____ #3 _____ #4 _____	<b>MMR</b> (Measles, Mumps, Rubella) 2 doses required	#1 _____ #2 _____
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**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 \_\_\_\_\_

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

**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: \_\_\_\_/\_\_\_\_/\_\_\_\_  
cdc.gov/tb and who.int/tb/en/ month day year

### 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 protection 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.

Forms can be found on the IDPH website or request one from your healthcare provider.

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