



STUDENT HEALTH HISTORY FORM

Among the forms you will complete in order to enroll at Ottawa University, none is more important than your properly completed health history. In order to ensure we have adequate knowledge of you and your health background, please fill it out carefully and completely. All information reported will be kept confidential and will become part of your health records in the Student Health Center. Ottawa University requires a health history for each student.

Please note this form can be completed by the student and/or parent. *Immunization questions may require assistance from a health care provider.*

Students who do not have an updated health history form on file in the Student Health Center are not eligible to receive treatment until a complete form is submitted.

Health Insurance

Ottawa University requires all students to have health insurance. Private health insurance policies are available for students who do not have other insurance coverage. For additional information about the health insurance plans, contact the Office of Student Affairs.

All student-athletes, including cheerleaders and members of the dance team, are required to have a secondary policy in addition to individual coverage. Ottawa University will share the cost of the policy with the student. For questions regarding health insurance or student-athletes, contact the Department of Athletics or the Office of Student Affairs.

Please submit the Student Health History Form and the Physical Form (for student-athletes) to the Office of Student Affairs via mail at Ottawa University, 1001 South Cedar Street, #2, Ottawa, KS 66067 or via fax at 785-229-1017.

PERSONAL INFORMATION – ALL STUDENTS

Last Name	First Name	Middle Initial
Permanent Address		
City	State	ZIP Code
Telephone	Country	Country Code (International Student)
Date of Birth	Gender	Social Security Number

FAMILY CONTACT INFORMATION – ALL STUDENTS

Father's Name	Father's Employer	
Work Phone	Cell Phone	Home Phone
Mother's Name	Mother's Employer	
Work Phone	Cell Phone	Home Phone

EMERGENCY CONTACT INFORMATION – ALL STUDENTS

Primary Person to Contact in Case of an Emergency	Relationship to Student	Emergency Phone
Work Phone	Cell Phone	Home Phone
Emergency Contact Address		
City	State	ZIP Code

In case the primary contact cannot be reached, please list a secondary contact:

Secondary Person to Contact in Case of an Emergency	Relationship to Student	Emergency Phone
Work Phone	Cell Phone	Home Phone
Emergency Contact Address		
City	State	ZIP Code

PHYSICIAN INFORMATION – ALL STUDENTS

Family Physician	Telephone Number	Fax Number
Address		Country
City	State	ZIP Code

Please list the primary care physician for insurance purposes, if different from above:

Primary Care Physician	Telephone Number	Fax Number
Address		Country
City	State	ZIP Code

HEALTH HISTORY – ALL STUDENTS

Is there a history of the following in your family? Please circle yes or no.

Cancer	Yes	No	Tuberculosis	Yes	No	Heart Disease/Heart Attack Under 50	Yes	No
Diabetes	Yes	No	Kidney Disease	Yes	No	Sudden Death at Young Age	Yes	No
Syncope (Passing Out)	Yes	No	Hypertension	Yes	No	Sickle Cell Disease or Trait	Yes	No

If yes, please explain: _____

Are you taking any medications? If yes, list: _____

Are you allergic to any medication? If yes, list: _____

DISEASE/ILLNESS HISTORY – ALL STUDENTS

Please put a check the box if you have now or have you ever had:

- | | | | | |
|--|---|---|--|--|
| <input type="checkbox"/> Abnormal Heart Beat | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Malaria | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heat Exhaustion/Stroke | <input type="checkbox"/> Measles | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mental Problems | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> Birth Deformities | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Hernia | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Small Pox |
| <input type="checkbox"/> Bone/Joint Weakness | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Head Injury | <input type="checkbox"/> High/Low Blood Sugar | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Unusual Shortness of Breath |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hives | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Vision Difficulty |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Kidney Troubles | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Whooping Cough |

INJURY HISTORY – ALL STUDENTS

Please put a check in the box if you have now or have you ever had an injury or illness involving the following:

- | | | | | | |
|--|---------------------------------------|--------------------------------|--------------------------------|-----------------------------------|--------------------------------|
| <input type="checkbox"/> Abodomen/Pelvis | <input type="checkbox"/> Back | <input type="checkbox"/> Elbow | <input type="checkbox"/> Head | <input type="checkbox"/> Knee | <input type="checkbox"/> Thigh |
| <input type="checkbox"/> Ankle | <input type="checkbox"/> Calf | <input type="checkbox"/> Foot | <input type="checkbox"/> Heart | <input type="checkbox"/> Neck | <input type="checkbox"/> Wrist |
| <input type="checkbox"/> Arm | <input type="checkbox"/> Chest/Breast | <input type="checkbox"/> Hand | <input type="checkbox"/> Hip | <input type="checkbox"/> Shoulder | |

DETAILED HEALTH HISTORY – STUDENT-ATHLETES ONLY

Circle the appropriate answer and explain more if necessary:

- Yes No 1. Have you ever been "knocked out" or experienced a concussion? If yes, how many? _____ Have you been hospitalized? Yes No
- Yes No 2. Have you ever had a "burner" or "stinger"? If yes, how many? _____
- Yes No 3. Have you ever passed out?
- Yes No 4. Has your physical activity ever been limited by a heart problem?
- Yes No 5. Have you ever been withheld from participating in a sport for medical reasons?
- Yes No 6. Do you wear glasses or contacts? If yes, do you wear them while playing? Yes No
- Yes No 7. Do you have any dead, missing, chipped, or broken teeth? If yes, how many and where? _____
- Yes No 8. Do you wear dental appliances (braces or dentures)? _____
- Yes No 9. Have you had any injuries to the neck or back nerves, vertebrae (bones) or vertebral discs? _____
- Yes No 10. Have you had any surgery on your neck or back?
- Yes No 11. Do you experience pain in the back? If yes, indicate frequency _____
- Yes No 12. Have you been told you injured ligaments or cartilage of either knee?
- Yes No 13. Have you experienced a severe ankle sprain?
- Yes No 14. Have you had any fractures within the last two years? If yes, indicate body location and date _____
- Yes No 15. Have you had any joint dislocations within the last two years? If yes, indicate body location and date _____
- Yes No 16. Have you had surgery within the last two years? If yes, indicate body location and date _____
- Yes No 17. Do you have a pin, screw or plate somewhere in your body because of a bone or joint surgery? If yes, indicate body location and date _____

MENSTRUAL HISTORY – FEMALE STUDENT-ATHLETES ONLY

Age of Onset _____ Interval between Periods _____ Duration of Periods _____

Do you require medication? Yes No Do you take Birth Control Pills? Yes No Do you have menstrual Problems? Yes No

Do you have a history of ovarian cysts? Yes No Do you experience heavy prolonged bleeding? Yes No Any other problems? _____

PROOF OF IMMUNIZATION – ALL STUDENTS

Ottawa University policy requires that students, regardless of age, submit a copy of their updated immunization records. Students born on or after 1957 must have two doses of MMR vaccine. International students must have a TB skin test within three months prior to the start of courses or proof with a negative chest X-ray.

Tetanus _____ Polio _____ TB Skin Test _____
MMR I _____ MMR II _____ Results of TB Skin Test _____
Diphtheria _____ DT Booster _____

If positive, chest X-ray results: _____

IMMUNIZATION EXEMPTION – ALL STUDENTS WITHOUT IMMUNIZATION

The petitioning student's physician must sign the following statement in order to be admitted without the above immunizations.

Physician's Signature _____ Date _____
Address _____ Country _____
City _____ State _____ ZIP Code _____
Phone Number _____ Fax Number _____

INSURANCE INFORMATION – ALL STUDENTS

Insurance Company _____ Policy Number _____ Group Number _____
City _____ State _____ ZIP Code _____
Policyholder's Name _____ Policyholder's Company _____
Policyholder's Phone Number _____ Policyholder's Social Security Number _____ Policyholder's Date of Birth _____

Does the above mentioned policy cover the following:

Yes No 1. Prescriptions. If yes, what is the policy number? _____

Yes No 2. Dental. If yes, what is the policy number? _____

Yes No 3. Optical. If yes, what is the policy number? _____

Does the above mentioned policy require pre-authorization for surgery? Yes No

Does the above mentioned policy require pre-authorization for medical care? Yes No

Does the above mentioned policy have a designated primary care physician? Yes No

Policyholder's Signature _____ Date _____

AUTHORIZATION – ALL STUDENTS

Authorization of treatment permission is hereby granted for treatment of the above-named student by a qualified health professional in the Trump Student Health Center of Ottawa University.

Student's Signature _____ Date _____

For students under the age of 18:

Parent's Signature _____ Date _____

If you have any questions or concerns regarding the Student Health History form, please contact the Office of Student Affairs at Ottawa University at 785-242-5200.

A COPY OF BOTH SIDES OF YOUR INSURANCE CARD MUST ACCOMPANY THIS FORM.

FOR OFFICE USE ONLY

Student's CX Number: _____ Enrollment Date: _____

OU Mailbox Number: _____ Phone Number: _____