

Student Health History

Office of Student Affairs • Health Services

In order to holistically support you in your educational endeavors, Ottawa University requires incoming student to complete a Student Health History form. <u>This form is required for all incoming students</u>. Please complete this form completely. All information reported will be kept confidential and will become part of your health records in the Student Health Center. Please note that this form can be completed by the student and/or parent.

Completion of this document requires a copy of your immunization record along with your insurance card. If you are completing this form online, please have those electronic documents available to attach. If you are completing the paper form, please attach the required documents.

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

Full Name		Nickname		DOB	OUID	
Do you participate in athlet	tics at Ottawa University? 🗖 Y	Yes □ No If Yes, w	hich sport(s)			
Medications Do you currently take medi ADHD, depression, etc.)	cation(s)?	ase list the medications yo	ou take (including birth con	trol and any psychotrop	oic medications for anxiety,	
Are you allergic to any med	lications?	se list the medications yo	u have an allergy to			
Disease/Illness History						
Please put check (√) the both Abnormal Heart Beat ☐ Allergies ☐ Asthma ☐ Birth Deformities ☐ Bone/Joint Weakness ☐ Chest Pain ☐ Chicken Pox ☐ Convulsions	Ox or boxes if you have now o Diabetes (select type) Type I Type II Diphtheria Eating Disorder Fainting Spells Head Injury Headaches Hearing Problems	☐ Heat Exhaustion/ Stroke ☐ Hepatitis ☐ Hernia ☐ High Blood Pressure ☐ High/Low Blood Sugar	☐ Kidney Troubles ☐ Malaria ☐ Measles ☐ Mental Health ☐ Issues ☐ Mononucleosis ☐ Mumps ☐ Pneumonia	□ PTSD (Post Traumatic Stress Disorder) □ Rheumatic Feve □ Scarlet Fever □ Seizures/Epileps □ Sickle Cell □ Skin Condition	of Breath r □ Vision Difficulty □ Whooping Cough	
□ Depression Please explain any marked	☐ Heart Murmur	☐ Hives		☐ Small Pox		
illness involving the followi ☐ Abdomen/Pelvis ☐ Ankle ☐ Arm	ox or boxes if you have now o ng: Back Calf Chest/Breast	□ Elbow □ Foot □ Hand	☐ Head ☐ Heart ☐ Hip	dislocation of a muscle, ☐ Knee ☐ Neck ☐ Shoulder	tendon, bone or joint) or Thigh Wrist	
Physician Information				_		
Family PhysicianAddress			Telephone Number City/State/Zip	Fax	Fax Number	
	ian for insurance purposes, if dif	ferent from above	orty/ otatic/ zip			
,			Telephone Number	Fax	Number	
Address						
Proof of Immunization Ottawa University require have two doses of the MI	s students, regardless of ag MR vaccine. International st sir immunization record to t	ge, to submit a copy of t tudents must have a TB	heir updated immunizatio	on records. Students b	orn in or after 1957 must	
Insurance Information Ottawa University require	s all students to carry healt	h insurance. Please att a	ach a copy of your insurar	nce card to this form.		
Policy Holder's Name Telephone Numbe				Relationship of Policy H	lolder to you	

Detailed I	History						
1.	☐ Yes	☐ No	Have you had a medical illness or injury since your last check up or sports physical?				
2.	☐ Yes	☐ No	Do you have an ongoing or chronic illness?				
3.	☐ Yes	☐ No	Have you ever been hospitalized overnight?				
4. 5.	☐ Yes☐ Yes	☐ No ☐ No	Have you ever had surgery? Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?				
6.	☐ Yes	☐ No	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?				
7.	☐ Yes	☐ No	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?				
8.	☐ Yes	□ No	Have you ever had a rash or hives develop during or after exercise?				
9.	☐ Yes ☐ Yes	☐ No ☐ No	Have you ever passed out during or after exercise?				
	☐ Yes	☐ No	Have you ever been dizzy during or after exercise? Have you ever had chest pain during or after exercise?				
	☐ Yes	☐ No	Do you get tired more quickly than your friends do during exercise?				
	Yes	☐ No	Have you ever had racing of your heart or skipped heartbeats?				
	☐ Yes	☐ No	Have you had high blood pressure or high cholesterol?				
	☐ Yes ☐ Yes	□ No □ No	Have you ever been told you have a heart murmur? Has any family member or relative died of heart problems or of sudden death before age 50?				
	☐ Yes	☐ No	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?				
	☐ Yes	□ No	Has a physician ever denied or restricted your participation in sports for any heart problems?				
	Yes	☐ No	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?				
	☐ Yes	☐ No	Have you ever had a head injury or concussion? When? How many? How many? Have you ever been knocked out, become unconscious, or lost your memory?				
	☐ Yes ☐ Yes	□ No □ No	Have you ever been knocked out, become unconscious, or lost your memory? Have you ever had a seizure?				
	☐ Yes	☐ No	Have you ever had a serzure: Have you ever had numbness or tingling in your arms, hands, legs, or feet?				
	☐ Yes	☐ No	Have you ever had a stinger, burner, or pinches nerve?				
	☐ Yes	☐ No	Have you ever become ill from exercising in the heat?				
	☐ Yes	☐ No	Do you cough, wheeze, or have trouble breathing during or after activity?				
	☐ Yes☐ Yes	☐ No ☐ No	Do you have asthma? Do you use an inhaler before exercise?				
	☐ Yes	☐ No	Do you have seasonal allergies requiring medication?				
	☐ Yes	☐ No	Do you use any special protective or corrective equipment or devises that aren't usually used for our sport or position (for				
	_	_	example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?				
	☐ Yes	☐ No	Have you had any problems with your eyes or vision?				
	☐ Yes☐ Yes	☐ No ☐ No	Do you wear glasses, contacts, or protective eyewear? Do you want to weigh more or less than you do now?				
	☐ Yes	☐ No	Do you lose weight regularly to meet weight requirements for your sport?				
	☐ Yes	☐ No	Has a doctor told you or a family member that you are at risk for blood disorders (for example, Sickle Cell, Hemophilia, etc)?				
	☐ Yes	☐ No	Were you born without or are you missing a kidney, testicle or any other organs?				
	☐ Yes	☐ No	Do you feel that you have fatigue or increased shortness of breath with activity?				
	☐ Yes IALES ONI	□ No ∨	Do you have any concerns that you would like to discuss with the doctor or nurse?				
	☐ Yes	□ No	Have you begun menstruation? If yes, approximately when was your first period?				
40.	Yes	☐ No	If yes, are you ever experiencing any problem (i.e. irregularity, pain, etc.)?				
Idontify VE	S rocnone	oc (by numl	per) and explain				
identity it	.o respons	es (by Hulli	Jerly and explain				
		unseling S					
To assist	with the c	ontinued s	uccess of the student, and continuity of care for counseling services if so involved, the following information is requested:				
Have you ever received a mental health evaluation or treatment? □ Yes □ No If yes, would you like for a staff member in Counseling Services to follow up with you? □ Yes □ No							
Have	e you evei	r received a	academic support for any learning issue(s)?				
			questing accommodations to be academically successful at Ottawa University? ☐ Yes ☐ No				
	If yes, Pl	ease descr	ibe the type of accommodation that you will require and the diagnosis that prompted your request for accommodations				
Name of (Current Co	ounseling o	r Psychiatric Provider				
Address _							
City			State Zip Code				
Telephon	e Number						
In Case o							
			versity to contact_(Name of Provider) if I am experiencing a				
Mental H	alth Crisi	s and rele	ase to/receive from_(Name of Provider) diagnostic information and treatment				
information for the purpose of stabilization of my mental health. I hereby give my consent for release of the above identified information.							
แแบบเกลน์ใ	אוו וטו נוופ	purpose of	Stabilization of thy mental health. Thereby give my consent for release of the above identified information.				
Student	Signature						
Signatu	re of Paren	t, or Guardia	n, if student is under the age of 18 Date				



Student Health History

Office of Student Affairs • Health Services

Disclosure

Permission to disclose to those involved in my care at:

Ottawa University Health Services
1001 S Cedar Street
Ottawa, KS 66067

I h	nereby allow Ottawa	a University Health Services Providers to	disclose the following health information:						
	☐ Appointment times and dates								
	☐ Tests that have been received								
	☐ Test results								
	Other health	information							
To	the following peop	ole because they are involved with my h	ealth care:						
	☐ Dean/Assista	ant Dean of Student Affairs, Ottawa Uni	versity, Ottawa, KS						
	☐ Counselor, O	ttawa University, Ottawa, KS							
	☐ Parent(s)	Name(s)							
		Relationship	Phone						
		Name (a)							
		Relationship	Phone						
	☐ Spouse	Name(s)							
		Relationship	Phone						
	☐ Friend	Name(s)							
		Relationship							
	☐ Other	Name(s)							
	_ 00.	Relationship							
Student Signature		 Date							
Signature of	f Parent, or Guardian,	if student is under the age of 18	Date						