

# Student Health Immunization & Insurance Form



## RELEASE OF INFORMATION

The Waldorf Student Health Services assures that all medical information received is confidential and will be released only as necessary for the student's health and welfare. My (Our) signature on this form authorizes the release of information between the Director of the Student Health Services, athletic trainer, coaches, and health care providers. It also authorizes the release of medical information between any other health care providers providing care to registered Waldorf College students.

This authorization for Release of Information will remain in effect from the date on which this form is signed throughout the student's enrollment at Waldorf College. I (We) understand we may revoke this authorization at any time by giving written notice to the Student Health Service.

Student \_\_\_\_\_  
(Please print)

Student \_\_\_\_\_  
SIGNATURE (Required)

Parent (or Guardian) \_\_\_\_\_  
SIGNATURE (Required if student is under age 18)

## INFORMATION TO BE COMPLETED BY THE STUDENT

Date of entry to Waldorf (month, year) \_\_\_\_\_ Entering as: First-year student  Transfer  Returning

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M  F

Living on Campus  Living Off Campus (F.C. Address)  Commuting to Waldorf

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Country of Citizenship \_\_\_\_\_ Country of Residence \_\_\_\_\_

Marital Status: Single  Married  Other

## EMERGENCY CONTACTS

Name, Address, Relationship \_\_\_\_\_ Phone a. (\_\_\_\_) \_\_\_\_\_

Name, Address, Relationship \_\_\_\_\_ Phone b. (\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Please return this form in enclosed envelope to: Admission Office, 106 S. 6th St., Forest City, IA, 50436**

**IMMUNIZATION HISTORY**

**REQUIRED** DATE GIVEN  
**M.M.R. (Measles, Mumps, Rubella)**  
12 months or older #1 \_\_\_\_\_  
5 years or older #2 \_\_\_\_\_

**If given separately:**  
**Measles** 1st \_\_\_\_\_  
2nd \_\_\_\_\_  
**Mumps** 1st \_\_\_\_\_  
**Rubella** 1st \_\_\_\_\_

**Tetanus-Diphtheria**  
Date primary series completed \_\_\_\_\_  
Last booster \_\_\_\_\_

**Polio**  
Date primary series completed \_\_\_\_\_  
Booster \_\_\_\_\_

**Varicella (Chicken Pox)**  
Had disease Yes \_\_\_ No \_\_\_  
If no, 2 doses required one month apart  
(If vaccinated before age 13, Vaccinated 1st \_\_\_\_\_  
only one dose required; 2nd \_\_\_\_\_  
after age 13, two doses required.)

**Tuberculosis Screening**  
PPD or Mantoux (BCG not accepted) Date given \_\_\_\_\_  
Must be within past 12 months  
Results:  positive  negative \_\_\_\_\_ mm induration  
Chest X-ray Date given \_\_\_\_\_  
(If positive, chest x-ray required.) Results \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY INSURANCE**  
Insurance Company Name \_\_\_\_\_ Company Phone \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_ Plan Number \_\_\_\_\_  
Insurance Company Mailing Address \_\_\_\_\_

**POLICY HOLDER INFORMATION**  
Policy Holder Full Name \_\_\_\_\_ Relation to Student \_\_\_\_\_  
Policy Holder Date of Birth \_\_\_\_\_ Policy Holder Employer \_\_\_\_\_  
Does policy require pre-authorization for out of network case?  Yes  No Please Explain: \_\_\_\_\_  
Are there treatments, conditions, illnesses that are not covered by this policy?  Yes  No Please Explain: \_\_\_\_\_

**SECONDARY INSURANCE (if applicable)**  
Insurance Company Name \_\_\_\_\_ Company Phone \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_ Plan Number \_\_\_\_\_  
Insurance Mailing Address \_\_\_\_\_  
Policy Holder Full Name \_\_\_\_\_ Relation to Student-Athlete \_\_\_\_\_  
Policy Holder Date of Birth \_\_\_\_\_ Policy Holder Employer \_\_\_\_\_

**RECOMMENDED** DATE GIVEN  
**Hepatitis B**  
1st \_\_\_\_\_ 2nd \_\_\_\_\_ 3rd \_\_\_\_\_

**Meningitis**  
The American College Health Association recommends that students consider a meningitis vaccine to reduce the risk for potentially fatal bacterial meningitis. (For questions, see enclosed meningitis letter and consult your health care provider.)

**Hepatitis A**  
1st \_\_\_\_\_ 2nd \_\_\_\_\_

**HPV**  
1st \_\_\_\_\_ 2nd \_\_\_\_\_

**OTHER IMMUNIZATIONS**  
(May be received after enrollment for travel, influenza, etc.)  
TYPE DOSE DATE GIVEN  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*\* Attach photocopy of both the front and back of policy holder's card. \*\***