Pre-Enrollment Health Requirements

Name _____ Date of Birth _____ Student ID # J _____
LAST FIRST MIDDLE

Local Address _____ Student Phone Number _____
STREET CITY STATE ZIP

Local Address _____ Email Address _____
STREET CITY STATE ZIP

REQUIRED IMMUNIZATIONS FOR ALL CONCORDIA UNIVERSITY STUDENTS

○ I understand that I am required to submit a copy of previous immunizations (i.e. school record or from your healthcare provider). The copy **MUST** be attached to this form. For waiver information, please contact the Health Center at 402-643-7224 or **HealthCenter@cune.edu**.

MEASLES (RUBEOLA) IMMUNITY

○ _____ First MMR (measles, mumps, rubella). Must be after first birthday.
MONTH DAY YEAR

○ _____ Second MMR (measles, mumps, rubella). No sooner than 30 days after first MMR.
MONTH DAY YEAR

OR

○ _____ Blood test for Rubeola Measles. A copy of the test results is required and must be attached to this form.
MONTH DAY YEAR

OR

○ Born before January 1, 1957 (You do not have to submit records or additional information).

TUBERCULOSIS (TB) SCREENING

Have you ever had a positive TB skin test: ○ Yes ○ No

Have you ever had close contact with anyone who was sick with TB? ○ Yes ○ No

Are you from or have you lived for two months or more in Asia, Africa, Central or South America or Eastern Europe? ○ Yes ○ No

If yes, where? _____

Have you ever been vaccinated with BCG? ○ Yes ○ No

If you answered yes to any of the above questions, Concordia University requires that a health care provider complete a tuberculosis risk assessment within six months prior to the start of classes. All cost associated with the assessment shall be the responsibility of the student. A TB risk assessment form will be provided.

MENINGOCOCCAL

Nebraska state law requires post-secondary institutions to provide students and parents information related to the meningococcal disease.

○ I have read the information on Meningococcal disease on page 14 and at **cdc.gov/meningitis/index.htm** and **cune.edu/HealthCenter**.

○ Yes, I have been vaccinated. _____ ○ No, I have not been vaccinated
MONTH DAY YEAR

AUTHORIZATION FOR TREATMENT

PARENT/GUARDIAN MUST SIGN BELOW FOR AUTHORIZATION OF CARE FOR STUDENTS UNDER 19 YEARS OLD

I authorize Concordia University Health Center, Seward, Neb. to provide medical and/or mental health care to

Student Name _____ Student ID J#_____

Services may include but are not limited to diagnostic examinations, verification and/or administration of immunizations, and necessary medical treatment and mental health counseling.

I further understand, according to Nebraska law, that once the above named minor reaches age 19 my consent for treatment is no longer required.

Signature of student: _____ Date: _____

Signature of parent/guardian: _____ Date: _____

Please enclose this form in the postage paid envelope.
Concordia University, Attn: Health Center, 800 N. Columbia Avenue, Seward, NE 68434