Medical History

Health Center Information (required to be on file in Health Center)

CONFIDENTIAL

Name _____ **Soc. Sec. Number** _____
First M. Last

Address _____
Street City State ZIP

Date of Birth _____ **Age** _____ **Cell Phone** _____

○ Male ○ Female ○ Unmarried ○ Married ○ Divorced

Date of Last Physical Examination _____

Name and Address of Health Care Provider _____

IN AN EMERGENCY, CONTACT:

Name _____ **Relationship** _____

Address _____
Street City State ZIP

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Personal Health History

Acute Infectious Disease

Yes No
- ○ ○ Chicken Pox
- ○ ○ COVID-19 Date_____
- ○ ○ Hepatitis
- ○ ○ HIV
- ○ ○ Kidney or bladder infections
- ○ ○ Mononucleosis
- ○ ○ MSRA infection
- ○ ○ Pneumonia
- ○ ○ Rheumatic Fever
- ○ ○ Sexually Transmitted Infections
- ○ ○ Sinus infections, recurrent
- ○ ○ Tonsillitis or strep throat, recurrent
- ○ ○ Tuberculosis
- ○ ○ Typhoid Fever

Diseases or Health Concerns

Yes No
- ○ ○ Anemia
- ○ ○ Arthritis
- ○ ○ Asthma
- ○ ○ Bleeding, abnormal
- ○ ○ Cancer
- ○ ○ Colitis or colon problems
- ○ ○ Congenital heart problems
- ○ ○ Dental problems
- ○ ○ Depression/Anxiety
- ○ ○ Diabetes
- ○ ○ Dizziness or fainting
- ○ ○ Drug or alcohol dependency
- ○ ○ Eating Disorder
  Type: _____
- ○ ○ Frequent urination
- ○ ○ Gall Bladder or liver disease
- ○ ○ Gastric or duodenal ulcer
- ○ ○ Hearing deficit
- ○ ○ Heart disease
- ○ ○ Hernia
- ○ ○ High Blood Pressure
- ○ ○ Migraines/severe headaches
- ○ ○ Orthopedic problem
- ○ ○ Sickle Cell Trait
- ○ ○ Seasonal Allergies
- ○ ○ Seizure Disorder
- ○ ○ Skin Problems, chronic
- ○ ○ Vision Deficit
  Contact lens/glasses
  Last Exam Date _____

While at Concordia will you:

Yes No
- ○ ○ Need a special diet
- ○ ○ Need consultations with a physician
- ○ ○ Require restricted physical activity
- ○ ○ Be taking prescription medicine or injections

Have you ever had?

Yes No
- ○ ○ Surgery
- ○ ○ Serious injury (head, broken bone, etc.)
- ○ ○ Psychiatric or psychological counseling
- ○ ○ Physical disability
- ○ ○ Learning disability

Allergic reaction to:
- ○ ○ Medication
- ○ ○ Food
- ○ ○ Stinging insects
- ○ ○ Pollen

Type
_____
_____
_____
_____
_____

_____
_____
_____
_____

Comment on all positive answers

Use this section to comment on all positive answers and to describe any serious medical or mental conditions, medications and medical recommendations. If you have a potentially serious medial condition, we recommend you provide a medical history summary from your physician (diagnosis, recommended treatment and follow-up, and any other pertinent information).

_____

_____

Family History

	Age	State of Health (Excellent, Good, Fair, Poor)	Occupation	Age at Death	Cause of Death
Father					
Mother					
Siblings					

Have your father, mother, brother, sister or grandparent ever been diagnosed as having any of the following conditions:

Yes	No		Relationship
◯	◯	Asthma	
◯	◯	Cancer	
◯	◯	Diabetes	
◯	◯	Epilepsy	
◯	◯	Heart disease	
◯	◯	Alcoholism	
◯	◯	Abnormal bleeding tendency	
◯	◯	High blood pressure	
◯	◯	Migraine or severe headaches	
◯	◯	Celiac disease	

To the best of my knowledge, the above information is accurate. I understand the information I provided will be used to assist medical personnel in case of emergency.

STUDENT SIGNATURE **DATE**

Pre-Enrollment Health Requirements

Name _____ **Student ID J#** _____
First M. Last

Address _____
Street City State ZIP

Birth Date _____ **Age** _____ **Email** _____

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.

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. If you have any questions, please contact the Health Center at 402-643-7224 or **healthcenter@cune.edu**.

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 13 and at **cdc.gov/meningitis/index.html** 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, Nebraska, 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, telehealth services-which students are able to refuse at any time and could also mean the student may have to travel off campus for services, through telehealth appointments students will know who is present during their appointment and may exclude anyone during this appointment as well. If the student is needing to see one of the providers in person. Services through Student health include necessary medical treatment and mental health counseling.

Students have access to medical information from telehealth consultation. Confidentiality is maintained through the health center and counseling areas.

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

_____

STUDENT SIGNATURE **DATE**

_____

PARENT/GUARDIAN SIGNATURE **DATE**

PLEASE UPLOAD A COPY OF YOUR IMMUNIZATION RECORDS AND COVID VACCINATION (IF APPLICABLE).

○ I don't receive immunizations/covid vaccination (please contact andreea.baker@cune.edu)

Assumption of Risk and Waiver of Liability Release

PLEASE READ THE FOLLOWING CAREFULLY.
If you have any questions or concerns, please visit with an attorney before signing this document. This release must be signed before participation in activities at Concordia University, Nebraska ("University") is allowed.

I agree that photographs, pictures, slides, movies, video, or other media coverage of me may be taken in connection with my participation in the Activity without compensation from Concordia and consent to the use of photographs, pictures, slides, movies, videos, or other media coverage for any legal purpose.

I acknowledge that my participation in certain activities including, but not limited to, intercollegiate athletics intramural sports, use of the Walz Human Performance Complex ("the Walz"), P.E. Center, University stadium field/track, adjacent University athletic fields and the City of Seward's Plum Creek Park may be hazardous, that my presence and participation are solely at my own risk, and that I assume full responsibility for any resulting injuries, damages, or death.

In consideration of being allowed to participate in such activities and/or being provided access and the opportunity to use the Walz and other University facilities and equipment, and in full recognition and appreciation of the danger and risks inherent in such physical activity, I do hereby waive, release and forever discharge the University, its officers, directors, agents, employees and representatives, from and against any and all claims, demands, injuries, actions or causes of action, for costs, expenses or damages to personal property, or personal injury, or death, which may result from my presence at or participation in any such University activities.

I further agree to indemnify and hold the University, its officers, directors, agents, employees and representatives harmless from any loss, liability, damage or costs including court costs and attorney's fees incurred as a result of my presence at or participation in any such activities. I also understand that this Assumption of Risk and Waiver of Liability Release binds me, my personal representatives, estate, heirs, next of kin and assigns.

I have read the Assumption of Risk and Waiver of Liability Release and fully understand it and agree to be legally bound by it.

Student Name _____ **Student ID J#** _____

Date of Birth _____ **Sport(s) if applicable** _____

Email _____ **Phone** _____

_____

STUDENT SIGNATURE **DATE**

If 18 years of age or younger, signature of parent/guardian is also required.

I, as the parent or guardian of the above-named minor, have read the Assumption of Risk and Waiver of Liability Release, fully understand it, and hereby voluntarily agree and execute the Assumption of Risk and Waiver of Liability Release on behalf of myself as well as the above-named minor and agree that the minor and I are legally bound by it.

Full Name _____ **Relationship** _____

Campus Department and Phone, if applicable _____

Email _____ **Phone** _____

_____

PARENT/GUARDIAN SIGNATURE **DATE**

Medical Insurance Requirements for International Students

(Required to be on file in Health Center)

○ New Student ○ Returning Student

○ Spring ○ Fall ○ Year 20 _____

Every student must complete this form as a new student and with any subsequent changes to the information below. This form authorizes treatment and provides important information to hospitals, clinics and attending physicians.

Name _____ **Student ID J#** _____
First M. Last

Date of Birth _____ **Sport(s) if applicable** _____

Address _____
Street City State Province Country Country Code/ Zip

Foreign Cell _____ **Domestic Cell** _____

Concordia University, Nebraska requires all international students to have a certain level of health insurance coverage that will cover potential or existing injury, sickness, and medical issues, emergency medical evacuation, repatriation/return of remains, etc. while in the United States. ***Travel insurance and medical insurance in other countries does not cover this requirement.***

Keep in mind

- Medical coverage is not provided automatically for anyone in the U.S.
- Medical costs can be very expensive without insurance coverage.
- The lowest monthly price quote may not be the best coverage – especially if needing coverage for follow-up care for athletic injuries, chronic issues, pre-existing conditions, etc.
- Coverage should fit personal needs (age, medical conditions, athletics, etc.)
- Coverage must be arranged before arrival and for entire time in the U.S. - August (arrival day) through May (departure day). Students who stay in the U.S. over the summer should arrange for coverage for the entire year.
- Concordia provides basic accident coverage for all full-time undergraduate students (this will also cover accidental athletic injury) but this is supplemental only, not general health and medical insurance.

Concordia has chosen this provider for our students to use:
International Student Insurance 1-877-758-4391
internationalstudentinsurance.com/schools/concordiauniversity-nebraska

You can choose from four plans and levels of coverage. **Athletes must use Budget plan or higher.**

Choose a plan that covers your situation

- Relatively Low Deductible – do you want to keep out of pocket costs as low as possible, watch for a low deductible, copay or coinsurance limit per condition, or per policy period.
- Mental Health Coverage – do you need a plan for in-patient and out-patient mental health care?
- Pre-existing Condition Coverage – do you need coverage for prior health conditions? Watch for waiting periods limits.
- Required - Emergency Medical Evacuation Coverage - transports student to the nearest medical facility that can provide appropriate care – either by ground or air transportation.
- Required - Repatriation/Return of Remains Coverage - provides financial assistance to the family if a student passes away while outside their home country.

If you have questions coverage please contact – Julie Johnston Hermann, Director of Global Opportunities (PDSO)
Julie.Johnston@cune.edu

Insurance Understanding and Authorization for International Students

Please provide a copy of your medical insurance policy verifying dates of coverage and level of coverage.

Medical Insurance Provider _____

Plan _____

Policy Number _____

Website _____ **Phone** _____

Coverage Date: From _____ **To:** _____

Is pre-authorization required to obtain treatment?

○ Yes ○ No

Is a second opinion required before surgery?

○ Yes ○ No

Medical Insurance Coverage Understanding and Authorization

I understand that international students are required to have medical insurance that will cover medical issues while in the United States. I may have insurance that covers me while in my home country, but I must arrange for coverage recommended above while in the U.S. I will arrange for medical coverage before arriving in the U.S., looking for coverage that meet my particular personal needs, such as athletic injuries, follow-up care, chronic issues, pre-existing conditions or dependents. I will provide proof of appropriate medical coverage each semester.

I hereby grant permission to any physician, hospital or clinic to which I am referred by the Concordia University Health Center and/or Athletic Training Staff to treat any health problems or injuries deemed reasonably necessary for my well-being. I also hereby authorize Concordia University Health Center and/or Athletic Training Staff to treat any health problems or injuries for which I seek treatment and to release medical information necessary to process insurance claims in order to receive benefits.

Intercollegiate Athletes: Your signature below authorizes the Concordia University Health Center, Coaches, Athletic Trainers, team physician, and athletic administration to discuss any information concerning illness or injury relative to my past, present or future participation in athletics at Concordia University, Nebraska. You have the right to revoke any part of this at any time by sending written notification to the director of health services or the athletic trainer.

- The insurance policyholder needs to sign for release of insurance information.
- The parent or guardian needs to sign for authorization for treatment and for release of information if student is less than 19 years of age.

_____

PRINTED NAME OF STUDENT **SIGNATURE OF STUDENT** **DATE**

_____

SIGNATURE OF PARENT/GUARDIAN **DATE**