# Pre-Enrollment Health Requirements

THIS FORM MUST BE COMPLETED PRIOR TO CLASS REGISTRATION

**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. ______________
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:

**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.

______________________________________________

**STUDENT SIGNATURE** **DATE**

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**PARENT/GUARDIAN SIGNATURE** **DATE**

**PLEASE ATTACH A COPY OF YOUR IMMUNIZATION RECORDS.**

PLEASE ENCLOSE THIS FORM IN THE POSTAGE PAID ENVELOPE.