2001 South Summit Avenue
Sioux Falls, South Dakota 57197

STUDENT HEALTH RECORD

Augustana College requires all students to complete the Student Health Record and Immunization form as a condition of admission (enrollment). Return this form before arriving on campus for your first academic term to: ***Student Health & Counseling Services, Box 771, Augustana College, Sioux Falls, SD 57197***

Last Name First Name Middle Name

Home Address City or Town State Zip Country Date of Birth (MM/DD/YY)

Student Cell Number

FAMILY HISTORY Have you or any of your relatives had any of the following:

AILMENT	YES	NO	RELATIONSHIP	AILMENT	YES	NO	RELATIONSHIP
Tuberculosis				Diabetes			
Kidney Disease				Heart Disease			
Arthritis				Stomach Disease			
Asthma/Hayfever				Mental Health Disorder			
Seizure Disorder				Cancer			

PERSONAL MEDICAL HISTORY Answer all questions, comment on all positive answers

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
		Eye Disease			Chronic Fatigue			Hepatitis
		Ear, Nose, Throat Disease			Headache/Migraine			Gastroinstestinal Disease
		Surgery-describe type below			Asthma			Recurrent Diarrhea
		Mental Health Disorder			Hay Fever			Gallbladder Disease
		Genetic Disorder			Tuberculoisis			Infectious Mononucleosis
		Handicaps			Hemophilia			Hernia
		Eating Disorder			High Blood Pressure			Sexually Transmitted Disease
		Learning Disability			Rheumatic Fever			Diabetes
		Do you smoke?			Heart Disease			Urinary Tract Infection
		Do you use alcohol/other drugs?			Disease or Injury of Joints			Kidney Disease
		Head Injury with unconsciousness			Back Problems			Seizure Disorder
		Anemia			Cancer			Other

MEDICAL ALERT CONDITIONS

I have the following “Med-Alert” condition:____________________

I am allergic to the following medications: ____________________

I have the following on-going chronic illnesses:____________________

Are you currently taking any medications? If so, what____________________

Please comment on all active answers, including dates: ____________________

Family Physician Name Phone # Fax #

Street Address City State Zip Code

NAME DATE OF BIRTH

IMMUNIZATION RECORD

Augustana College requires the following immunizations as a condition of enrollment. If you were born before January 1, 1957, you are exempt from this requirement. Age exempt? ☐ Yes ☐ No

REQUIRED IMMUNIZATIONS

MMR (two doses required)	____/____/____ MONTH DAY YEAR	____/____/____ MONTH DAY YEAR	
MENINGOCOCCAL	____/____/____ MONTH DAY YEAR		

RECOMMENDED IMMUNIZATIONS

Hepatitis B (3 doses required)	____/____/____ MONTH DAY YEAR	____/____/____ MONTH DAY YEAR	____/____/____ MONTH DAY YEAR
Hepatitis A (2 doses required)	____/____/____ MONTH DAY YEAR	____/____/____ MONTH DAY YEAR	
Polio (Last date)	____/____/____ MONTH DAY YEAR		
Tetanus-Diptheria (Every 10 years)	____/____/____ MONTH DAY YEAR		
PPD (Tuberculin)	____/____/____ MONTH DAY YEAR		

HEALTH INSURANCE

Students will be automatically enrolled in the College's insurance plan if proof of other insurance is not provided.
To view the brochure: www.eiia.org/augie or you may call 800-951-4320.

IMPORTANT – Student should carry a copy of the health policyholder insurance card

CONFIDENTIAL SHARING AGREEMENT AND CONSENT FOR TREATMENT

The College assures that medical information will be regarded as confidential and shared only as necessary for the student's immediate safety. Health Service will not release medical information to parents unless the student signs a separate release of information specific to each illness/incident.

If a serious illness or accident should occur, every effort will be made to contact parents or guardian. However, in the event that delay in medical or surgical treatment may be detrimental to the health of the student, authorization for consultation and treatment by area physicians is requested. Augustana College recognizes the importance of cooperating with the student's family physician, clinic, or hospital in providing health care while the student is enrolled in college. In order to secure or exchange health information, it is necessary to have the permission of the student and/or parent or guardian. On occasion, information regarding the physical or mental health status of a student may be shared with the dean of students, college counselors and athletic training staff if sharing that information will benefit the student. No information will be provided to other college personnel such as faculty or advisors without specific consent of the student.

Permission is hereby granted to share health information with my family physician, clinic, hospital, and insurance company if this information is determined by the College to be beneficial to my health.

Student name (please print) Signature of student Date

Signature of parent/guardian (only needed if student is under age 18) Date