Congratulations on being accepted to Northwest!

About University Wellness Services

University Wellness Services, operating out of the Wellness Center, is the hub for all campus health services. This encompasses clinical, personal development and counseling, health promotion, public health, and nutritional services. While remaining committed to quality outpatient care, we focus on wellness, not only as prevention of disease, but also as a philosophy of life. This philosophy emphasizes self-responsibility and taking an active role in maintaining one’s health. We believe true health must consider the individual as an integration of mind, body and spirit. Please visit www.nwmissouri.edu/wellness for more information.

Health Insurance

Health Insurance information

University Wellness Services has the capability to bill your insurance company for the services provided. If you have health insurance, please do the following:

- Submit copies of both the front and back of your health insurance card to University Wellness Services
- Contact your insurance company to make sure we are an in-network provider. Your insurance company will need the following information:
  Dr. Gerald W. Wilmes, 800 University Drive, Maryville, MO 64468

THIS FORM, AND IMMUNIZATION RECORDS, MUST BE COMPLETED AND SUBMITTED BY THE FOLLOWING DATES:

- Fall Trimester – August 1
- Spring Trimester – December 1
- Summer Trimester – April 1

Please return directly to Wellness Services, DO NOT submit with other Admissions materials.

If you have a disability or significant health problem, please contact Wellness Services before coming to campus.
Vaccination Requirements

In addition to the required vaccination information requested below, please send us copies of any other vaccination records that you may have.

Measles, Mumps and Rubella (MMR) Vaccination

Required for all students

Northwest Missouri State University policy requires that ALL newly enrolled students born after January 1, 1956 must comply with the two dose Measles Vaccination Policy. Students who do not comply will have a hold put on their registration for future classes.

☐ Please check here if you were born before January 1, 1956 or if you will be taking all courses online or through one of Northwest’s outreach centers.

Submit the following to University Wellness Services:

• Documentation of **two doses of the MMR vaccine.**
  The first dose must have been given at age 12 months or later. The second dose must have been at least one month after the first dose.

  **OR**

• Documentation of a **TITER**, which is a blood test proving immunity to Measles (Rubeola), Mumps and Rubella.

Meningococcal vaccination requirement

Required for all students living on campus

Effective July 1, 2015, Missouri state law requires all students residing in residence halls at Northwest Missouri State University to be immunized against Meningococcal Disease. This means all students living on campus must submit documentation that they have received the Meningococcal Vaccine to University Wellness Services. It is the student’s responsibility to provide this documentation. Per the state law, a student will not be allowed to move into the residence halls until he/she has completed this requirement.

Per Center for Disease Control (CDC) guidelines, students are required to receive the vaccine (or a booster dose) after the age of 16. Records that only show vaccination prior to 16 years of age will not be compliant with Northwest’s immunization requirement.

☐ Please check here if you **WILL NOT** be living on campus.

Submit to University Wellness Services the following:

• Documentation of **one dose of meningococcal vaccine after the age of 16.**

For more information on Meningococcal Disease and the vaccine, visit:
www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.pdf.

Compliance Checklist

☐ Completed Health History Form;
☐ Immunization Record showing 2 doses of MMR Vaccine;
☐ Immunization Record showing Meningococcal Vaccine after the age of 16;
☐ Copy (front and back) of Insurance Card
Health History Form

Personal information

Last name ____________________________ (Maiden name) ____________________________ Legal First Name ____________________________ Middle ____________________________ Preferred Name ____________________________

Address ______________________________________ City ____________________________ State ____________________________ ZIP ____________________________

(______) ____________________________ ____________________________ (______) ____________________________ ____________________________

Phone ____________________________ Cell phone ____________________________ Date of birth ____________________________

Country of birth ____________________________ Social Security Number ____________________________

Preferred Spoken Language(s) ____________________________

Gender Identity: 

☐ Man 

☐ Woman

☐ Trans or Transgender (Please Specify) ____________________________

☐ Another Identity (Please Specify) ____________________________

Insurance information

Policy holder name ____________________________ Date of birth ____________________________ Relationship to student ____________________________

Member ID number ____________________________ Group number ____________________________

Health insurance carrier (Ex. Aetna, BCBS, etc.) ____________________________ Phone number ____________________________

Insurance carrier address ____________________________ City ____________________________ State ____________________________ Zip ____________________________

Medical history

Do YOU have a present or past history of the following: (check all that apply)

☐ Alcohol abuse ____________________________ ☐ Drug abuse ____________________________ ☐ Intestinal/stomach trouble ____________________________

☐ Anemia ____________________________ ☐ Ear trouble/hearing loss ____________________________ ☐ Joint disease/injury ____________________________

☐ Arthritis ____________________________ ☐ Eating disorder ____________________________ ☐ Measles, Red ____________________________

☐ Asthma ____________________________ ☐ Eye disease/problems ____________________________ ☐ Menstrual problems ____________________________

☐ Back problems ____________________________ ☐ Gallbladder trouble ____________________________ ☐ Migraine headaches ____________________________

☐ Cancer ____________________________ ☐ Hay fever (recurrent) ____________________________ ☐ Mononucleosis, infectious ____________________________

☐ Colitis ____________________________ ☐ Head injury ____________________________ ☐ Mumps ____________________________

☐ Convulsions/Seizures ____________________________ ☐ Headache (recurrent) ____________________________ ☐ Pneumonia ____________________________

☐ Cough (chronic) ____________________________ ☐ Heart disease/problems ____________________________ ☐ Paralysis ____________________________

☐ Depression ____________________________ ☐ Hepatitis/Jaundice ____________________________ ☐ Polio ____________________________

☐ Diabetes ____________________________ ☐ Hernia/rupture ____________________________ ☐ Psychological counseling ____________________________

☐ Disability/Handicap ____________________________ ☐ High blood pressure ____________________________ ☐ Rheumatic fever ____________________________

☐ Other ____________________________

Current medications (list all, including birth control) ____________________________

Do you have allergies to drugs, foods, metals? Yes / No ____________________________

Hospitalizations/surgeries ____________________________

Family history (place relationship in blank) ____________________________

☐ Alcohol/drug abuse ____________________________ ☐ Death before 50 ____________________________ ☐ Elevated cholesterol ____________________________

☐ Cancer/type ____________________________ ☐ Diabetes ____________________________ ☐ Heart disease ____________________________

☐ Mental illness ____________________________

Consent for treatment

Students under 18

I grant permission to University Wellness Services (to include clinic, counseling, and health education services), Northwest Missouri State University, to treat my son/daughter as may be necessary, and to refer to private care when special service is needed.

PARENT/GUARDIAN SIGNATURE ____________________________ DATE ____________________________

For all students

By signature, I verify that the information provided on the form is true and I give permission for such diagnosis, therapeutic and operative procedures as may be deemed necessary for me.

Student signature ____________________________ Date ____________________________
Tuberculosis (TB) Screening questionnaire

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

Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years? (If yes, please CIRCLE the country) □ YES □ NO

Have you ever traveled to/in one or more of the countries listed below? (If yes, please CHECK the country/ies AND indicate the date(s) and duration of travel) □ YES □ NO

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Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2014. Countries with incidence rates of ≥20 cases per 100,000 population. For further updates, refer to http://www.who.int/tb/country/en/

Have you ever been a resident and/or employee of high risk congregate settings (e.g. correctional facilities, long-term care facilities, and homeless shelters)? □ YES □ NO

Have you ever been a volunteer of health-care worker who served clients who were at increased risk for active TB disease? □ YES □ NO

Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease – medically underserved, low-income, or abusing drugs or alcohol? □ YES □ NO

If you answered YES to any of the above, you must:

- Schedule a TB test at the University Wellness Services
- Provided documentation of a TB test done in the United States within the past 12 months. TB tests done outside of the United States will not be accepted.
- If prior treatment for active TB disease or latent TB infection has been completed, written documentation must be submitted.

Chest X-rays will be required for anyone with a positive test.

Additional American College Health Association immunization recommendations:

- Polio
- Tetanus, Diphtheria, Pertussis
- Hepatitis A
- Varicella
- Human Papillomavirus
- Hepatitis B
- Influenza
- Pneumococcal

For more information contact University Wellness Services.