Student Housing

Date of First Semester Enrollment:
Year _____ (check beginning semester)
❒ Fall (August – December)
❒ Spring (January – May)
❒ Summer (May – July)

Confidential Health Information

Please print

Name _____ Previous Last Name _____
(Last, First, Middle)

Date of Birth _____ Sex: ❒ Male ❒ Female Student ID# _____

Address _____ City _____ State _____ Zip _____

Person(s) to notify in emergency:

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Telephone (_____) _____ Work Telephone (_____) _____

Family Physician:

Name _____

Address _____ City _____ State _____ Zip _____

Telephone (_____) _____

Medical Insurance Company _____ Policy No. _____

Northeast Community College requires all students living in campus housing to have all immunizations up to date.

Childhood Diseases: (Please check Yes or No)

Have You Had	Yes	No	Have You Had	Yes	No
a. Chickenpox			d. Measles (German)		
b. Diphtheria			e. Mumps		
c. Measles (Red)			f. Scarlet Fever		

Medication (List any medication taken regularly):

_____

Allergies:

Medications ❒ Yes ❒ No (List) _____
Others ❒ Yes ❒ No (List) _____

Immunizations – Include an official immunization record from your doctor's office or the state health department.

A. Tetanus – Diphtheria
- ❒ Completed primary series of tetanus-diphtheria Immunizations (four doses with DTaP or DTP)
  Month: _____Year: _____
- ❒ Last tetanus-diphtheria booster (Recommended dose is every 10 years)
  Month: _____Year: _____

B. Hepatitis B (series of three)
  Month: _____ Year: _____
  Month: _____ Year:
  Month: _____ Year: _____

C. Polio
  Month: _____Year: _____

D. M.M.R. (Measles, Mumps, Rubella)
- ❒ Dose 1 – given at age 12-15 months or later
  Month: _____ Year: _____
- ❒ Dose 2 – given at age 4-6 years or later, and at least one month after first dose
  Month: _____ Year: _____

E. Meningitis
  Month: _____ Year: _____
  Month: _____ Year: _____

F. Tuberculosis Screening (International Students Only)
  Month: _____ Year: _____

Personal Health History (Please check Yes or No)

Have You Had	Yes	No	2. Acute Diseases:	Yes	No
1. Chronic Diseases:			a. Rheumatic Fever		
a. Arthritis			b. Infectious Mononucleosis		
b. Asthma			c. Hepatitis		
c. Bronchitis			d. Poliomyelitis		
d. Cancer			e. Tonsillitis		
e. Convulsions/Seizures			f. Venereal Disease		
f. Colon Diseases			g. Typhoid Fever		
g. Deaf/Hearing Loss			h. Other		
h. Depression (Prolonged)			3. Have you had any surgical operations (e.g., appendectomy, tonsillectomy, hernia)?		
i. Diabetes					
j. Eating Disorder			4. Have you ever been hospitalized? Specify, including date(s).		
k. Epilepsy					
l. Emotional/Behavioral Problems			5. Do you wear glasses or contact lenses regularly?		
m. Emphysema					
n. Gallbladder/Liver Disease			6. Are you now under the care of State Rehabilitation?		
o. Hayfever					
p. Headaches/Migraines			7. Have you been advised to seek and/or received psychiatric or psychological help?		
q. High Blood Pressure					
r. Heart Disease			8. Do you have any physical or emotional conditions which might make it inadvisable for you to carry a full study load?		
s. Kidney Disease					
t. Malaria					
u. Orthopedic Problems					
v. Speech Problems			This health information is optional and requested for the purpose of reporting to federal compliance agencies only and will not be used in determining admission status.		
w. Thyroid					
x. Tuberculosis					
y. Ulcer					
z. Other					

If you checked yes to any of the above questions 1-8, use space below to provide additional information.

_____

_____

_____

_____

This information is given in confidence for the sole use of the Northeast Community College Student Housing Office. I certify the above history is complete and accurate to the best of my knowledge.

Signature of Student _____ Date _____

CONSENT TO BE SIGNED BY PARENT OR GUARDIAN IF STUDENT IS UNDER 19 YEARS OF AGE:

In the event of emergency, illness, or injury, permission is hereby granted to the staff of the Student Housing Office at Northeast Community College to refer the above-named student to a local physician and/or health care facility. Further permission is granted to allow the student to undergo any treatment that is deemed necessary by the said attending physician.

Signature of Parent or Guardian _____

Mail this form to: Student Housing Office, Northeast Community College, P.O. Box 469, Norfolk, NE 68702-0469

Date	Northeast Community College Student Housing Office Notes

MENINGOCOCCAL VACCINATION RECOMMENDATION

SECTION 1 – NAME OF STUDENT

STUDENT'S NAME _____ Student ID _____
(Please Print) First MI Last

DOB _____

COMPLETE SECTION 2 **OR** SECTION 3

SECTION 2 – IMMUNIZATION RECORD
To be completed by a health care provider

The above-named student received Meningococcal vaccine on _____.

Health Care Provider Name _____ Phone (____)_____-_____

Address _____
Street City State Zip

Signature of Provider _____ Date _____
Documentation from a physician showing receipt of vaccine or a copy of immunization record is also acceptable.

SECTION 3 – VACCINE WAIVER

Complete Section 3A, if you are a student 18 years of age or older.
Complete Section 3B, if you are a student under 18 years of age. A parent or guardian signature is also required.

SECTION 3A: For individuals 18 years of age or older:
I am 18 years of age or older. I have received and read the information provided by Northeast Community College explaining the risks of Meningococcal disease and am aware of the effectiveness and availability of the vaccine. I acknowledge that the disease is rare, but life-threatening. I understand that the State of Nebraska recommends each newly enrolled student residing in on-campus housing for the first time be vaccinated against Meningococcal disease. I voluntarily agree to release, discharge, indemnify, and hold harmless Northeast Community College, its officers, employees, and agents from any and all costs, liabilities, expenses, claims, or causes of action on account of any loss or personal injury that might result from my decision to waive the immunization for Meningitis.

SIGNATURE OF STUDENT _____ DATE _____

SECTION 3B: For individuals under 18 years of age:
We have received and read the information provided by Northeast Community College explaining the risks of Meningococcal disease, and are aware of the effectiveness and availability of the vaccine. We acknowledge that the disease is rare, but life-threatening. We understand that the State of Nebraska recommends each newly enrolled student residing in on-campus housing for the first time be vaccinated against Meningococcal disease. We voluntarily agree to release, discharge, indemnify, and hold harmless Northeast Community College, its officers, employees, and agents from any and all costs, liabilities, expenses, claims, demands, or causes of action on account of any loss or personal injury that might result from our decision to waive the immunization for Meningitis.

SIGNATURE OF STUDENT _____ DATE _____

Please check appropriate box and print name:
❑ PARENT
❑ GUARDIAN _____
First MI Last

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

Northeast Community College
Faith Regional Physician Services
Stephanie Brundieck, LCSW-Counselor
801 E Benjamin Avenue-Union 73
Norfolk, NE 68702
402-844-7277

Krystal Preister-Registered Nurse
801 E Benjamin Avenue- Union 73
Norfolk, NE 68702
402-844-7176 Fax 402-844-7431

CONSENT FOR TREATMENT OF A MINOR and PERMISSION FOR STUDENT HEALTH AND COUNSELING SERVICES

STUDENT'S NAME_____ Date of Birth_____
PLEASE PRINT

Under Nebraska law, a minor may not receive healthcare or counseling services without permission of a parent/legal guardian except under specified circumstances. A minor is an individual who has not yet reached her/his 18th birthday (for mental health services) and 19th birthday (for healthcare services). This consent can be revoked at any time by written notification from the undersigned parent/guardian. The consent will automatically expire one year from signature date.

I do hereby indemnify and hold harmless the physician, clinic, hospital, college, and other persons who act in reliance upon this authorization. Any questions or concerns related to this form or to the proposed treatment can be directed to the staff of the above offices.

As the parent or legal guardian with the authority to consent of behalf of the minor student named above, I hereby give consent for the minor to seek health care, clinic care, hospital care, treatment, and/or counseling services by the professional staff of the Student Health & Counseling Services at Northeast Community College and the staff of Faith Regional Health Services and Faith Regional Physicians Services.

Please list any known allergies _____

_____

List other important medical information: _____

_____

Emergency Contact Number/Numbers: _____

_____ _____
Parent/Guardian signature and date Witness Signature and date (in office only)

Mail: Northeast Student Health and Counseling Services
PO Box 469
Norfolk, NE 68702-0469
fax: 402-844-7431
email: stephanie@northeast.edu
email: studenthealthnurse@northeast.edu