

Dear New International Student:

Welcome to Webster University!

At Webster University Student Health Services we believe that good health can be an important factor in educational achievement and personal success. To help us best serve you, in preparation for your admission to Webster University, all residents are required to submit a completed Student Health Packet and carry health insurance. All international students on a F-1 visa or J-1 visa, and Optional Practical Training are required to be enrolled in the Webster University Student Health Insurance Plan, with no possibility of a waiver.

To avoid any delay checking into the residence halls or apartments during move-in day, your Student Health Packet must be complete. A complete Student Health Packet consists of the following forms:

- Completed Emergency Information and Medical Release
- Student Health Insurance Wavier and Medical History
- Physician Assessment (campus residents only)

Residents who do not provide a complete Student Health Packet by the deadlines stated below will automatically 1) be charged for the Webster University Student Insurance Plan, 2) be delayed at move-in, and 3) have a hold placed on your student account, which will inhibit your ability to register for classes.

Move-In Date	Health Packet Postmarked by:
August 2008- Fall I	July 1, 2008
October 2008- Fall II	September 12, 2008
January 2009- Spring I	December 1, 2008
March 2009- Spring II	January 16, 2009
May 2009- Summer	March 13, 2009

If you are charged for insurance you will have until move-in day to complete and return the health packet. Charges CANNOT be removed after move-in day; therefore it is imperative that you return your completed health packet by the appropriate deadline.

Once we receive your health packet an email will be sent to your Webster University account with a checklist verifying completion of your packet.

Student health Services is open Monday-Friday 8:30 am-4:30pm, central time. If you have questions you may call us at (314) 968-6922 or (800) 839-0996. We look forward to seeing you soon.

Sincerely,

Student Health Services

Emergency Information and Medical Release

(Please Print in Ink)

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Last Name	First Name	M.I.	Cell Phone
			<input type="checkbox"/> Male <input type="checkbox"/> Female
Student ID	Social Security	Date of Birth (mm/dd/yy)	

Check All That Apply

- Residence Hall Resident
 Nurse Anesthesia Student
 Student Athlete
 Seen In Student Health Services By A Nurse
 Webster Village Apartment Resident
 International Student
 Returning Resident That Lived On Campus Last School Year

Emergency Contact Information (#2 is optional)

1) _____

Name	Relationship To Student	Primary Phone	Secondary Phone
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2) _____

Name	Relationship To Student	Primary Phone	Secondary Phone
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Authorization of Treatment and Medical Information Release

In the event of an emergency, I authorize Webster University to make arrangements as reasonably necessary to maintain my health and well-being. I understand the cost of medical attention and transportation are not the responsibility of Webster University, its employees, agents, representatives, teachers and/or volunteers.

I hereby consent to permit Webster University Health Services and Webster University Counseling/Life Development to:

- Facilitate and/or administer medical treatment, first aid, hospitalization, emergency psychiatric care, and physician follow-up care according to their professional judgement.
- Release/obtain personal medical records and medical insurance data about me in the event of an emergency or for the purpose of certification of injury/illness and verification of coverage. In accordance with HIPAA, this information is to be released on the condition that Webster University will not permit other parties access to the information without written consent of myself or other legally responsible party.

I have read, understand, authorize, and acknowledge the information as stated above for a period of one (1) year.

Student's Signature/Parent Guardian, if student is under 18 years old	Date
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Permission Notification (Optional)

I understand that Student Health Services will not release any information to parents, friends, or family members without written consent. I would like to authorize the person(s) listed below to receive information about any minor illness/injury without further authorization. Pregnancy, STD, or other sensitive medical conditions as defined by Student Health Services are not covered by this authorization. I understand that I may choose to remove the names listed at any time by completing and filing a new form with Student Health Services.

Name of Authorized Person To Receive Information	Relationship To Student
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Academic/Physical Accommodations and Mental Health Release of Information

The Academic Resource Center and Counseling/Life Development Offices offer students a wide variety of academic and mental health resources. Resources include: peer tutoring; testing center; writing center; special services for students with documented disabilities; psychiatric referrals; and counseling with a trained professional to identify and help overcome challenging life circumstances.

List any disability(ies) (learning, physical, psychological) and any history of psychiatric illness (depression, eating disorders, stress disorders) you have been diagnosed with:

By signing, I authorize Student Health Services to notify The Academic Resource Center and Counseling/Life Development of my diagnosis. I understand it is my responsibility to register to receive services.

Student's Signature/Parent Guardian, if student is under 18 years old	Date
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Last Name _____ First Name _____ M.I. _____ Cell Phone _____

Male Female

Student ID _____ Social Security _____ Date of Birth (mm/dd/yy) _____

Immunization History - All Vaccines Listed Are Required

Vaccine	mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy
Polio	#1	#2	#3	#4
Hepatitis B	#1	#2	#3	
Hepatitis A	#1	#2	Administered with Twinrix? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Varicella (Chicken Pox)	#1	#2	or Date of Disease	
MMR II	#1	#2	* Vaccine must be administered within previous 9 years. ** Must be within 3 years if Menomune was administered. *** Meningitis Vaccines that only cover strains A & C are not acceptable.	
Td/Tdap*		<input type="checkbox"/> Td <input type="checkbox"/> Tdap		
Meningitis***		<input type="checkbox"/> Menomunc** <input type="checkbox"/> Menactra		

The American College Health Association recommends the Quadrivalent Human Papillomavirus Vaccine (HPV) for all female college students 11 to 26 years old. Student Health Services offers the vaccine. Please contact us for details.

Tuberculosis Test - Required (All Lines MUST be completed)

Date Administered*	Date Read	Induration (mm)**	Provider Name (Print)
#1			
2-Step***			

*Test must received within the 6 months prior to entering campus housing.
 **An induration ≥ 10 mm requires a chest x-ray. Please include the radiological report with this form. X-rays should NOT be sent.
 *** 2 Step testing is required for Nurse Anesthesia Students

Physical Examination - Required

PE Date _____	HT _____	WT _____	BP _____	P _____	T _____	RR _____
Significant medical history and/or abnormal findings i.e..depression, eating disorder, learning disability..						
List All Medications Prescribed To Patient (N/A if none) -						

Provider Information - Required (All information MUST be completed)

Office Stamp:	Provider Name (Print):	Circle One MD DO NP
City, State:	Provider Signature:	
Phone: ()	Date Completed:	