



Welcome to Austin College! **These forms are both required and time-sensitive regardless of how you attend (in person or virtually).** Failure to complete the required information could affect your ability to move into your residence hall, participate in on-campus activities, and attend class.

The following items are required for new students:

- Personal Family History Form
- Mental Health History Form
- Disability Accommodations Form
- Authorization Form
- Physical Examination Form
- Immunization Form
- Waiver/Enrollment Instructions

PERSONAL AND FAMILY HISTORY

Personal and Family History: Please complete the form.

MENTAL HEALTH HISTORY FORM

Mental History Form: Please complete the form.

DISABILITY ACCOMMODATIONS FORM

Disability Accommodations Form: Students with documented disabilities who wish to utilize classroom accommodations are required to register with the College through the Office of the Vice President for Student Affairs. It is the student's responsibility to provide written documentation of the disabling condition, the impairment(s) the condition causes, and recommended accommodations. Determination of eligibility for services and of appropriate accommodations is made on an individual case-by-case basis. Please attach any support documents.

AUTHORIZATION SIGNATURE AND EMERGENCY CONTACT FORM

Please review and sign. All areas must be completed and signed by the student. If the student is less than 18 years of age at the start of the semester, the form must be signed by both the parent/legal guardian.

PHYSICAL EXAMINATION FORM

Physical Examination: A licensed Physician, Nurse Practitioner or Physician's Assistant **must complete and sign the Physical Examination form within a year of the start of classes.**

Athletes – Health Services will accept the physical form required by Austin College Athletics. Follow the link to the Pre-Participation Physical Evaluation form. http://www.acroos.com/information/trainingforms/Physical_Form.pdf

IMMUNIZATION FORM

Immunization Record: Your physician or their representative **must complete and sign** the immunization information. A copy of school records immunizations will suffice, providing it meets all of our requirements.

You may not move on campus, attend class, or participate in intercollegiate athletics without documentation of meningococcal (MCV4) vaccination 10 days prior to arrival on campus (see immunization page).

Failure to complete immunizations will result in weekly fines and/or impact your ability to register for the next semester.

STUDENT HEALTH INSURANCE

All Austin College, students/teaching assistants (full or part-time), are required to have medical insurance that is currently active. Student health insurance is available if you do not have other sources of health insurance.

You are required to upload copy of front and back of insurance card to waive student health insurance or to enroll if insurance is needed. You will be notified by when this task is available.

Failure to complete this task and have an approved waiver prior to the due date will result in the cost of the insurance being billed to your student health insurance.

STUDENT ATHLETES

You are encouraged to carefully check your family's insurance policy. If it does not cover intercollegiate athletics, it is recommended that you purchase the student insurance plan. If you choose to use your own insurance plan, you are required to turn your medical insurance information in to our office and to the Athletic Department separately. Failure to complete the waiver will result in your enrollment for the student health insurance.

Athletes are not permitted to participate in their team's activities prior to submission of all the required forms. You must turn your documents into our office in addition to uploading them on for the Athletics Department. Please contact Julie Travis at jtravis@austincollege.edu or call 903-813-2499, if you have any questions. The Athletic Trainer can be reached at 903-813-2514.

QUESTIONS

All other questions regarding your health packet can be answered by calling Adams Center at 903-813-2247 or emailing health@austincollege.edu.

RETURNING HEALTH PACKET

Email: health@austincollege.edu.

Mail: Health Services
Austin College
900 N. Grand Ave, Ste. 61629
Sherman, Texas 75090

Fax: 903-813-3188

Phone: 903-813-2247

Personal and Family History

Information on this page will be used by Health Services and is regarded as confidential. Release to other College personnel would be strictly on a need to know basis.

Student Name _____

DOB _____ Sex _____ Phone _____ Date _____

PARENT OR GUARDIAN _____	Relationship _____
Street Address _____	Home Phone (____) _____
City _____ State _____ Zip _____	Work Phone (____) _____

Father: <input type="checkbox"/> Living <input type="checkbox"/> Deceased Age at death _____ Cause _____ Occupation _____	Mother: <input type="checkbox"/> Living <input type="checkbox"/> Deceased Age at death _____ Cause _____ Occupation _____	Siblings: Number Living _____ Number Deceased _____ Cause _____
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Family Medical History

Have any of your blood relatives had any of the following?

<input type="checkbox"/> Allergies	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emotional Illness	<input type="checkbox"/> Kidney Disease	

Personal Medical History

Have you now or in the past had any of the following conditions?

<input type="checkbox"/> Anorexia <input type="checkbox"/> Bulimia <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Dental/Gum problems <input type="checkbox"/> Diabetes <input type="checkbox"/> Menstrual problems <input type="checkbox"/> Headaches <input type="checkbox"/> Migraine <input type="checkbox"/> Murmur <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Heart Disease Specify: _____ _____	<input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Neurological problems <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Seizures/Blackouts <input type="checkbox"/> Skin Diseases <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Wear Hearing Aid <input type="checkbox"/> Other _____ Allergies to Medicine <input type="checkbox"/> Aspirin <input type="checkbox"/> Codeine <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Other _____ _____	Diseases: <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV <input type="checkbox"/> Malaria <input type="checkbox"/> Measles <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Mumps <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Rubella <input type="checkbox"/> Rubeola <input type="checkbox"/> Scarlet Fever Allergies To Food/Other <input type="checkbox"/> Foods _____ <input type="checkbox"/> Seasonal Pollens <input type="checkbox"/> Wasp/Bee Stings <input type="checkbox"/> Other _____ _____	Orthopedic History: Injuries/Fractures _____ _____ Surgeries: <input type="checkbox"/> Gall Bladder <input type="checkbox"/> Hernia Repair <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Other _____ _____
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Do you have a medical disability? No Yes-Explain _____

Do you have special dietary needs? (Check yes here to be contacted by Dining Services.) No Yes

Are you receiving any ongoing treatment from a physician? No Yes-Explain _____

Are there medications involved? No Yes-List _____

Is local physician follow-up needed? No Yes

Is there any additional information Health Services should know in order to provide you with better health care?

Mental Health History

Adjustment to college is a challenge for all students. Students with psychological issues may experience more significant adjustment problems. For this reason, college personnel request that students disclose information to promote continuity of care, as well as informed intervention should a crisis occur, particularly during the first semester on campus.

All information disclosed on this form will be kept confidential and will be shared with appropriate College personnel on a need-to-know basis only. Please return your completed form to Health Services, using the enclosed return envelope.

Student Name _____ **DOB** _____ **Date** _____

Describe any medical or mental health problems or conditions that have required professional psychological care.

Have you had or experienced any of the following: **Yes** **No** **Age or Dates of Treatment**

- | | | | |
|---|--------------------------|--------------------------|--|
| Depression treated professionally..... | <input type="checkbox"/> | <input type="checkbox"/> | |
| Anxiety disorder..... | <input type="checkbox"/> | <input type="checkbox"/> | |
| Eating disorder..... | <input type="checkbox"/> | <input type="checkbox"/> | |
| Bipolar disease..... | <input type="checkbox"/> | <input type="checkbox"/> | |
| Asperger's Disorder (autism spectrum disorder)..... | <input type="checkbox"/> | <input type="checkbox"/> | |
| Obsessive-compulsive disorder..... | <input type="checkbox"/> | <input type="checkbox"/> | |
| Anger management issue..... | <input type="checkbox"/> | <input type="checkbox"/> | |
| Post-traumatic stress disorder (PTSD)..... | <input type="checkbox"/> | <input type="checkbox"/> | |
| ADD/ADHD..... | <input type="checkbox"/> | <input type="checkbox"/> | |
| Suicide attempt..... | <input type="checkbox"/> | <input type="checkbox"/> | |
| Suicidal ideation..... | <input type="checkbox"/> | <input type="checkbox"/> | |
| Sleep disorder..... | <input type="checkbox"/> | <input type="checkbox"/> | |
| Panic disorder..... | <input type="checkbox"/> | <input type="checkbox"/> | |
| Learning disability..... | <input type="checkbox"/> | <input type="checkbox"/> | |
| Anti-social or conduct disorder..... | <input type="checkbox"/> | <input type="checkbox"/> | |
| Alcohol or substance abuse or dependence..... | <input type="checkbox"/> | <input type="checkbox"/> | |

Other (please specify) _____

Are you now taking or have you ever taken medication for any of the above? _____

(Specify medication and dates) _____

Do you intend to begin or continue medication or counseling during college?... _____

Have you been hospitalized for a psychiatric disorder?..... _____

Have you been treated for alcohol and/or drug addiction? (Specify dates)..... _____

Disability Accommodations

Student Name: _____ Date: _____

DOB: _____ Phone Number: _____

The Academic Skills Center, located in room 211 of the Wright Campus Center, addresses the academic needs of students with documented physical, psychological and learning disabilities.

Accommodations are provided in accordance with the Americans with Disabilities Act Amendments Act, ADA-AA, for eligible students upon request. Eligible students must provide documentation that appropriately substantiates the need for requested accommodations.

Once you file appropriate documentation, you will meet with the Director of the Academic Skills Center to identify accommodations and other suitable academic strategies. At the beginning of each semester, you will be required to fill out paperwork with the director to request the use of accommodations for courses in which you are currently enrolled.

Please complete the following questions so that the College will have an idea of the services you may need. All information disclosed on this form will be kept confidential and will be shared with appropriate college personnel on a need-to-know basis only.

If you think you might need to request accommodations at any time while at Austin College, please complete this form and send a copy of any documentation you have to:
900 North Grand Avenue, Suite 61629, Sherman, TX 75090
903-813-2247

For more information about disability accommodations or the Academic Skills Center, please visit

<http://www.austincollege.edu/campus-life/academic-skills-center/>.

You may also contact us at ASC@austincollege.edu or call (903) 813-2454.

I do not require any accommodation.

1. What is the nature of your disability?

2. How and when was your disability diagnosed and documented?

3. What types of accommodations have you used?

4. What accommodations are you requesting at Austin College?

5. Are there any new accommodations you anticipate requesting? If so, please specify.



900 North Grand, Suite 61629 Sherman, TX 75090-4400

Student Name: _____ Student ID: _____

DOB: _____ Phone Number: _____

EMERGENCY NOTIFICATION

_____ PRIMARY NAME	_____ RELATIONSHIP	_____ DAY PHONE
_____ CELL PHONE		_____ EVENING PHONE
_____ SECONDARY NAME	_____ RELATIONSHIP	_____ DAY PHONE
_____ CELL PHONE		_____ EVENING PHONE

AUTHORIZATION

- I authorize the Health Services at Austin College to administer treatment by licensed nursing and medical personnel for emergency and routine health care. This would include assessment, treatment and, if necessary, referral or hospitalization. If health care is needed in the absence of Health Service personnel, a college representative may choose local health services on my behalf.
- I authorize disclosure of health care information related to my medical history, diagnosis, treatment, or prognosis in case of Emergency Room care or hospitalization to the following AC personnel:
 - Vice President for Student Affairs and Athletics
 - Dean of Students
 - Director of Health Services
 - Director of Counseling Services
 - Professional Residence Hall Staff
 - Athletic Trainer

Student Signature (& Guardian if student is under 18 years of age)

Date

Physical Examination

(Must be completed by a Physician, Nurse Practitioner or Physician's Assistant.)

Athletes may submit completed Pre-participation Physical Evaluation

TO THE EXAMINING PROVIDER: *Please review Personal and Family History and complete this form no more than one year prior to start of classes. Also, note that a **signature is required** from your medical provider.*

STUDENT NAME: _____ **DOB:** _____ Male Female

Pulse: _____ **Blood Pressure:** _____ **Height:** _____ **Weight:** _____

	Normal	Abnormal Findings
Head, Ears, Nose and Throat		
Eyes		
Respiratory		
Cardiovascular		
Gastrointestinal		
Genitourinary		
Musculoskeletal		
Metabolic/Endocrine		
Skin		

Does student plan to participate in an NCAA Intercollegiate athletic team sport? Yes No

If yes, which sport? _____

Athletes must complete Pre-Participation Evaluation Form.

If activity is limited, please explain. _____

Is this student on any medication? Yes No

Name and dosage? _____

Is this student under treatment for any physical condition?

Yes No Explain _____

Any recommendations for care of this student? _____

Is this the student's first visit to your office? No Yes

Recommendations for physical activity:

Unlimited Limited Temporary Permanent

Date of examination _____
Signature of Provider _____
Printed Name of Provider _____
Street Address _____
City, State, Zip _____
Phone (_____) _____

Immunization Record

Student Name: _____ Date of Birth: _____

The Immunizations Required for ALL Students Entering Austin College Are Listed Below

Persons seeking an exemption for religious reasons or reasons of conscience need to follow the State of Texas guidelines listed on their website <https://webds.dshs.state.tx.us/immco/affidavit.shtm> or link from Austin College Health Services site. If exemption is requested for medical reasons, an affidavit or certificate from your physician stating the medical risk and which immunizations cause this risk must be submitted including physician's signature, and stamp from clinic or office. Records from physician's office, health departments, or schools will be accepted in lieu of signature below. Make a copy of this record for yourself.

MENINGOCOCCAL (MCV4)

***Required by Texas State Law, if under 22 years old**

Booster required if >5 yrs before start of semester

TETANUS-DIPHTHERIA-PERTUSSIS (Tdap)

Required within the past 10 years

Date of Last Dose

MEASLES-MUMPS-RUBELLA (MMR)

Dose 1 – given at 12 months of age or after

Dose 2 – given at 4 years of age or later

POLIO

Date of Last Booster

VARICELLA (not required if has a history of Chicken Pox Disease)

Dose 1 – given at 12 months of age or after

Dose 2 – given at 4 years of age or later

History of Chicken Pox Disease Yes No

Year _____

HEPATITIS A

Dose 1 – initial dose

Dose 2 – given 6 months after the first

HEPATITIS B

Dose 1 – initial dose

Dose 2 – given 1 month after first dose

Dose 3 – given 6 months after first dose

TUBERCULOSIS (TB TEST) REQUIRED WITHIN THE PAST 1 YEAR.

Please provide proof of other types of testing. BCG is not acceptable.

1. TSpot, or TB Gold Date of Test _____ Result _____

2. PPD test Date Placed _____ Date Read _____ Results _____

3. If positive TB test a chest x-ray is required.

Date _____ and result of check x-ray _____

NOT REQUIRED

Meningococcal B (MenB) – Please note this is **not** the same as the above MCV4 that is required (see above). Two dose series. Booster if needed.

Dates _____ / _____ / _____

Covid-19 Vaccine Manufacturer: _____ Dose date(s) _____ / _____ / _____

Or submit copy of the vaccine card.

Health Care Provider Signature _____ Date _____



Dear Austin College Student,

Austin College is pleased to offer two ways to manage your required health insurance coverage. The first option is if you currently active medical insurance, you may waive-out (decline) the student health insurance. The second option is if you do not currently have health insurance you should enroll in the college student health insurance. Premiums for the student health insurance are below.

All students must login to the AHP website and waive/enroll in the student health insurance. Failure to do complete a waiver prior to the due date will result in your account being charged and enrolled in the plan.

<p>8/1/2021 – 7/31/2022</p> <p>\$2,297.00</p> <p>Waiver/Enrollment Period</p> <p>04/26/2021 – 7/01/2021</p>

*You can pick up coverage at any time during the year with a “Qualifying Life Event” by contacting our office.

ALL students must login to this system and follow the steps to EITHER waive the coverage or to enroll.

To Waive the of Student Insurance Plan

(If you currently have an active medical insurance plan and covers you for the whole academic year)

Step 1: Please have your medical insurance card on hand. Go to this link <https://austincollege.myahpcare.com/>

Step 2: Your user ID is your AC Student ID with one leading “0” in front (i.e. 035#####).

Step 3: Your password is your birthdate (i.e. 07051978)

Step 4: After logging-in, click on the red button to submit waiver. Complete the waiver form using the information from your medical insurance card. DO NOT leave any blanks. You can type N/A if it does not apply.

Step 5: Upload a copy of the front and the back of your insurance card to the form.

Step 6: Click “submit” at the bottom of the form when you are done. You should see confirmation appear that you have waived.

* If after following these steps, you are unable to log into your AHP account to waive, please contact AHP Customer Service at (855) 370-7215.

To Enroll in Student Insurance Plan

(If you do not have a currently active medical insurance for the academic year.)

Step 1: Go to this link <https://austincollege.myahpcare.com/>

Step 2: Your user ID is your AC Student ID with one leading “0” in front (i.e. 035#####).

Step 3: Your password is your birthdate (i.e. 07051978)

Step 4: Click on the green “One Click Enrollment” button.

Step 5: Read the information and type your initial to e-sign your consent

Step 6: Click “submit” at the bottom of the form when you are done. You should see confirmation appear that you have waived.

* If after following these steps, you are unable to log into your AHP account to waive, please contact AHP Customer Service at (855) 370-7215.