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](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 Sheila Smith at ssmith@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: __________________________ Last: __________________________ First: __________________________ Middle: __________________________

DOB: ______________ Sex: ______________ Phone: ______________ Date: ______________

<table>
<thead>
<tr>
<th>PARENT OR GUARDIAN</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address:</td>
<td>Home Phone: (____)</td>
</tr>
<tr>
<td>City: ___________</td>
<td>State: __________ Zip: __________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Father:</th>
<th>Mother:</th>
<th>Siblings:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living</td>
<td>Living</td>
<td>Number Living</td>
</tr>
<tr>
<td>Deceased</td>
<td>Deceased</td>
<td>Number Deceased</td>
</tr>
<tr>
<td>Cause: ___________</td>
<td>Cause: ___________</td>
<td>Cause: ___________</td>
</tr>
<tr>
<td>Occupation: ___________</td>
<td>Occupation: ___________</td>
<td></td>
</tr>
</tbody>
</table>

## Family Medical History

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

- Allergies
- Arthritis
- Asthma
- Cancer
- Diabetes
- Emotional Illness
- Heart Disease
- High Blood Pressure
- Kidney Disease
- Seizure Disorder
- Tuberculosis

## Personal Medical History

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

- Anorexia
- Bulimia
- Anxiety
- Depression
- Arthritis
- Asthma
- Bleeding Disorder
- Dental/Gum problems
- Diabetes
- Menstrual problems
- Headaches
- Migraine
- Murmur
- High Blood Pressure
- Low Blood Pressure
- Heart Disease

Specify: __________________________

<table>
<thead>
<tr>
<th>Allergies to Medicine</th>
<th>Diseases:</th>
<th>Orthopedic History:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td>Chicken Pox</td>
<td>Injuries/Fractures</td>
</tr>
<tr>
<td>Codeine</td>
<td>Hepatitis</td>
<td>__________________</td>
</tr>
<tr>
<td>Penicillin</td>
<td>HIV</td>
<td>__________________</td>
</tr>
<tr>
<td>Sulfa</td>
<td>Malaria</td>
<td>__________________</td>
</tr>
<tr>
<td>Other</td>
<td>Measles</td>
<td>__________________</td>
</tr>
<tr>
<td></td>
<td>Mononucleosis</td>
<td>__________________</td>
</tr>
<tr>
<td></td>
<td>Mumps</td>
<td>__________________</td>
</tr>
<tr>
<td></td>
<td>Rheumatic Fever</td>
<td>__________________</td>
</tr>
<tr>
<td></td>
<td>Rubella</td>
<td>__________________</td>
</tr>
<tr>
<td></td>
<td>Rubeola</td>
<td>__________________</td>
</tr>
<tr>
<td></td>
<td>Scarlet Fever</td>
<td>__________________</td>
</tr>
</tbody>
</table>

## Orthopedic History

Injuries/Fractures

- Gall Bladder
- Hernia Repair
- Tonsillectomy
- Other

## Surgeries

- | Foods |
- | Seasonal Pollens |
- | Wasp/Bee Stings |
- | Other |

- | Other |

- | Other |

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?

________________________________________________________________________________________

| Return Forms to Health Services 61629 |
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.

<table>
<thead>
<tr>
<th>Have you had or experienced any of the following:</th>
<th>Yes</th>
<th>No</th>
<th>Age or Dates of Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression treated professionally</td>
<td>□</td>
<td>□</td>
<td>________________________</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>□</td>
<td>□</td>
<td>________________________</td>
</tr>
<tr>
<td>Eating disorder</td>
<td>□</td>
<td>□</td>
<td>________________________</td>
</tr>
<tr>
<td>Bipolar disease</td>
<td>□</td>
<td>□</td>
<td>________________________</td>
</tr>
<tr>
<td>Asperger’s Disorder (autism spectrum disorder)</td>
<td>□</td>
<td>□</td>
<td>________________________</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder</td>
<td>□</td>
<td>□</td>
<td>________________________</td>
</tr>
<tr>
<td>Anger management issue</td>
<td>□</td>
<td>□</td>
<td>________________________</td>
</tr>
<tr>
<td>Post-traumatic stress disorder (PTSD)</td>
<td>□</td>
<td>□</td>
<td>________________________</td>
</tr>
<tr>
<td>ADD/ADHD</td>
<td>□</td>
<td>□</td>
<td>________________________</td>
</tr>
<tr>
<td>Suicide attempt</td>
<td>□</td>
<td>□</td>
<td>________________________</td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td>□</td>
<td>□</td>
<td>________________________</td>
</tr>
<tr>
<td>Sleep disorder</td>
<td>□</td>
<td>□</td>
<td>________________________</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>□</td>
<td>□</td>
<td>________________________</td>
</tr>
<tr>
<td>Learning disability</td>
<td>□</td>
<td>□</td>
<td>________________________</td>
</tr>
<tr>
<td>Anti-social or conduct disorder</td>
<td>□</td>
<td>□</td>
<td>________________________</td>
</tr>
<tr>
<td>Alcohol or substance abuse or dependence</td>
<td>□</td>
<td>□</td>
<td>________________________</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>□</td>
<td>□</td>
<td>________________________</td>
</tr>
</tbody>
</table>

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) □ □ ________________________

| Return Forms to Health Services 61629 |
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.

____________________________________________________________________________________
Student Name: ________________________________ Student ID: __________________

DOB: ____________________________ Phone Number: ________________________________

**EMERGENCY NOTIFICATION**

<table>
<thead>
<tr>
<th>PRIMARY NAME</th>
<th>RELATIONSHIP</th>
<th>DAY PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CELL PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEL PHONE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECONDARY NAME</th>
<th>RELATIONSHIP</th>
<th>DAY PHONE</th>
</tr>
</thead>
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<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CELL PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEL PHONE</td>
</tr>
</tbody>
</table>

**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: ________

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head, Ears, Nose and Throat</td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
</tr>
<tr>
<td>Genitourinary</td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td>Metabolic/Endocrine</td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
</tr>
</tbody>
</table>

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.

Is this student on any medication?  ☐ Yes  ☐ No
Name and dosage? ________________________________

If activity is limited, please explain.___________________________

Is this student under treatment for any physical condition?
☐ Yes  ☐ No Explain ________________________________
Any recommendations for care of this student? ________________________________

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

Is this the student’s first visit to your office?  ☐ No  ☐ Yes
Recommendations for physical activity:
☐ Unlimited  ☐ Limited  ☐ Temporary  ☐ Permanent

| Return Forms to Health Services 61629 |
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

— Date of Last Dose

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

— Date

HEPATITIS B

— Dose 1 – initial dose

— Dose 2 – given 1 month after first dose

— Dose 3 – given 6 months after first dose

— Date

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______________

| Return Forms to Health Services 61629 |
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.

```
8/1/2022 – 7/31/2023
$2,549.00
Waiver/Enrollment Period
04/26/2022 – 06/17/2022
```

*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/](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/](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.