GOSHEN COLLEGE

**Health & Wellness**
1700 S. Main St. Goshen, IN 46526
800.348.7422 | 574.535.7474 | Fax: 574.535.7195
**health@goshen.edu | goshen.edu/health**

# Student Health Information Form

Goshen College has contracted with Goshen Family Physicians (GFP) for medical services. To find more information please go to **goshen.edu/health.**

**ALL STUDENTS:** You are required to submit this information prior to living on campus or starting classes.

**ATHLETES:** You are required to complete this form **in addition to** your athletics medical packet.

## Instructions:

1. Complete all pages. Print clearly.
2. Submit this form and all required documentation by
   Mail: 1700 S. Main St. Goshen, IN 46525 OR Fax: 574.535.7195 OR Email: health@goshen.edu

## Personal Information:

Name: _____
Last First Middle

Date of birth: _____ / _____ / _____ Student ID Number: _____
MM DD YY

Permanent address: _____

City: _____ State: _____ Zip/Country: _____

Home phone: _____ Cell phone: _____

## Person to notify in case of a medical emergency:

Emergency contact name: _____ Relationship: _____

Address: _____ City: _____ State: _____

Home phone: _____ Cell phone: _____

This information falls under the overall understanding of educational records and the Federal Education Rights and Privacy Act (FERPA).

## Immunization record:

This requirement may be met in one of two ways:

1. Have your doctor or a medical provider complete this form and sign and date below.

**OR**

2. Obtain a copy of your **complete** immunization record from your medical provider's office, high school, college or health department and attach it to this form.

***Please read carefully as you may need a booster to meet requirements.***

## Required immunizations:

This information is **required** by Goshen College in compliance with the law set forth by the State of Indiana and Goshen College policy. If not completed, a restriction will be placed on the student's registration prior to second term until the form is completed and submitted. If applicable, please download a religious or medical exemption form from the Health and Wellness website and submit with your Confidential Health form.

Enter dates by Month / Day / Year

***All students***

1. **Measles-Mumps-Rubella (MMR):** (Two doses required after first birthday if born after 1956.)
   #1 ____ / ____ / ____ #2 ____ / ____ / ____
2. **Tetanus-Diphtheria-Pertussis Series (DPT, Td, DTap)** (Minimum of 3 doses):
   #1 ____ / ____ / ____ #2 ____ / ____ / ____ #3 ____ / ____ / ____ #4 ____ / ____ / ____ #5 ____ / ____ / ____

   **Booster within last 10 years - Tdap:** #1 ____ / ____ / ____
3. **Meningococcal Vaccine:** #1 ____ / ____ / ____ #2 ____ / ____ / ____

---

***International students only*** **- Tuberculosis Screening Required**

Tuberculosis screening must be done in the United States upon arrival to campus. Further evaluation may be needed.

Date Administered: ____ / ____ / ____ Date read: ____ / ____ / ____ Reaction in Millimeters _____

## Highly recommended immunizations:

4. **Varicella (Chicken Pox):** History of disease? Date (year): _____
   ***OR*** Vaccination dates: #1 ____ / ____ / ____ #2 ____ / ____ / ____
5. **Hepatitis A:** #1 ____ / ____ / ____ #2 ____ / ____ / ____
6. **Hepatitis B:** #1 ____ / ____ / ____ #2 ____ / ____ / ____ #3____ / ____ / ____
7. **Gardisil (HPV)** (for females only ages 9-26)**:** #1 ____ / ____ / ____ #2 ____ / ____ / ____ #3____ / ____ / ____
8. **Polio Series** (Minimum of 3 doses):
   #1 ____ / ____ / ____ #2 ____ / ____ / ____ #3 ____ / ____ / ____ #4 ____ / ____ / ____ #5 ____ / ____ / ____
9. **COVID-19**
   #1 ____ / ____ / ____ #2 ____ / ____ / ____ #3 ____ / ____ / ____

***(Not needed if providing complete immunization record)***

Medical Provider's Name *(print)*: _____ Telephone: _____

Medical Provider's Signature: _____ Date: _____

## Health Insurance Information:

- All students are required to have health insurance in order to defray medical costs while in college.
- It is recommended for students to keep a copy of their insurance card with them at all times.
- Check with your insurance provider to see what kind of health care coverage you have while attending Goshen College (i.e., out of state, out of network, etc.).
- Provide updated information to Goshen College if you have insurance coverage changes while enrolled at Goshen College.

**PARENTS/GUARDIANS:** PLEASE NOTIFY YOUR HEALTH INSURANCE COMPANY that your son/daughter will be a full time student at Goshen College, Goshen, Indiana, BEFORE arriving on campus. This will confirm whether your son/daughter will be covered while at Goshen College.

☐ I have private insurance.* If yes, name of Health Insurance Company: _____

☐ I have Medicaid coverage.* If yes, ☐ IN Medicaid ☐ Out-of-state Medicaid

☐ I do not have health insurance and recognize that I am financially responsible for all charges at the time of service for the medical care I receive from any medical provider.

Students who do not have health insurance can find information and resources for securing health insurance in Health and Wellness.

*Students with health insurance must provide a copy of their insurance card — front AND back

## Acknowledgement and Confirmation Statement:

This information is collected for the purpose of meeting the requirements of Indiana State law and Goshen College policies.

☐ I acknowledge that I have read and understand the information provided.

☐ I hereby state that, to the best of my knowledge, my answers are complete and accurate.

Student Signature: _____ Date: _____

Parent Signature: _____ Date: _____

***(MUST be signed by parent if student is under 18)***