UNIVERSITY OF MOUNT UNION STUDENT HEALTH RECORD

Last name_____ First Name_____ MI_____ Preferred Name_____

Home Address_____ City_____ State_____ Zip Code_____

Date of Birth_____ Biological Sex M____ F____ Gender Identity_____ Preferred Pronoun_____

Student's Cell Phone_____ Social Security #_____

EMERGENCY CONTACT: _____ Relationship_____

Home Phone_____ Cell Phone_____ Work Phone_____

INSURANCE INFORMATION **PLEASE ATTACH A COPY FRONT AND BACK OF INSURANCE CARD

PRIMARY INSURANCE:

Insurance Company_____

Address_____

Member ID_____ Group #_____

Primary Card Holder's Name_____ Primary Member's Date of Birth_____

Primary Card Holder's relationship to student_____

SECONDARY INSURANCE:

Insurance Company_____

Address_____

Member ID_____ Group #_____

Primary Card Holder's Name_____ Primary Member's Date of Birth_____

Primary Card Holder's relationship to student_____

CONFIDENTIALITY STATEMENT

All information on these pages is considered confidential and protected. The Student Health Center will not release medical information to anyone, including parents, unless the student signs a separate release of information specific to each illness/incident. The Privacy Statement and FAQs can be found on the Health Center website at www.mountunion.edu/health-center.

STATEMENT OF AUTHORIZATION

Authorization is hereby granted, for the health and welfare of the student, for the Physician or Physician Assistant to admit him/her to the hospital if necessary, and to refer this student to any duly licensed physician or surgeon when indicated. Permission is given to administer any medication, treatment, vaccines, etc., deemed necessary by the Student Health Center staff.

Signature of Student _____ Date_____

_____ Date_____

***Signature of Parent/Guardian (if student under age 18)

UNIVERSITY OF MOUNT UNION STUDENT HEALTH RECORD

STUDENT NAME_____ DATE OF BIRTH_____

Student's Medical History – Provide date and explanation for any "YES" answers

Have you ever had……	**Y**	**N**	**DATE**	**EXPLANATION**
Migraines or Frequent/Severe Headaches				
Seizures				
Cancer or other immune disorder				
Diabetes/other endocrine disorder (thyroid)				
Mononucleosis				
Blood Disorder				
AIDS/HIV				
Asthma				
Seasonal Allergies				
Tuberculosis				
High Blood Pressure				
Heart Murmur/Heart Disorder				
Gastrointestinal Disorder				
Hernia				
Kidney Disease				
Hepatitis or other Liver Disease				
Menstrual Irregularities				
Genetic Disorder				
Anxiety/Depression				
Other Mental Health Disorder				
Physical Disability				
Orthopedic Problems				
Substance Abuse				
Positive COVID 19				
Any other Condition/Illness				
Are you allergic to medication or latex?				
Other allergies?				
Do you take medication? Please list all				
History of surgeries				

Family Medical History (parent, grandparent, sibling)

Do any of your immediate relatives have or had…	**Y**	**N**	**Relationship**		**Y**	**N**	**Relationship**
Cancer				Seizure Disorder			
High Blood Pressure				Mental Health Disorder			
Sickle Cell Trait				Sudden Death (before 50)			
Lung Disease				Heart Disease			
Diabetes				Other			

I certify that, to the best of my knowledge, the information provided is complete and accurate.

Student Signature_____ Date_____

UNIVERSITY OF MOUNT UNION

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE (To be completed by ALL incoming students)

Name_____ **Date of Birth_____**

Have you ever had close contact with persons known or suspected to have active TB disease? YES_____ NO_____

Have you been a resident and/or employee of high-risk congregate settings (e.g., correction facilities, long-term care facilities, and homeless shelters? YES_____ NO_____

Have you been a volunteer or health care worker who served clients who are at increased risk of active TB disease? YES_____ NO_____

Have you ever been a member of any of the following groups that may have an increased incidence of latent tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? YES_____ NO_____

Have you had frequent or prolonged visits to one of more of the countries or territories listed below with a high prevalence of TB disease? (If yes, please CHECK the countries or territories below) YES_____ NO_____

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country below) YES_____ NO_____

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State Of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cote d'Ivoire
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Columbia
Comoros
Congo
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Eswatini
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Tajikistan
Thailand
Timor-Leste
Togo
Tokelau
Trinidad and Tobago
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

If the answer is **YES** to any of the above questions, University of Mount Union requires that you receive TB testing as soon as possible, but **at least prior to the start of the semester.**

TUBERCULIN (TB) SKIN TEST OR QUANTIFERON GOLD BLOOD TEST – <u>ATTACH RESULTS</u>

DATE_____ NEGATIVE_____ POSITIVE_____

****A positive TB test requires a chest x-ray ***Please attach results**

UNIVERSITY OF MOUNT UNION STUDENT HEALTH RECORD

Student's Name_____ Date of Birth_____

Please complete this form and include a copy of your immunization record. **ALL IMMUNIZATIONS ARE HIGHLY RECOMMENDED, HOWEVER **MANDATORY IMMUNIZATIONS ARE TWO DOSES OF MMR OR TITERS SHOWING IMMUNITY, AND A TDAP WITHIN THE LAST 10 YEARS.**

VACCINE	DOSE 1	DOSE 2	DOSE 3	DOSE 4	DOSE 5
Dtap Diphtheria, Tetanus Pertussis					
****Tdap (required within 10 years)**					
****MMR – 2 doses** Measles, mumps, rubella **Required**					
Varicella Chicken Pox					
Hepatitis B					
Hepatitis A					
Meningococcal					
HPV Human Papillomavirus					
Influenza Most recent					
IPV/OPV Polio					
COVID 19					

Statement of Exemption to Immunization: If you cannot complete the required vaccines, a waiver form must be returned to the Student Health Center. Note that students who have not been immunized may be excluded from class and residence halls if an outbreak of a vaccine preventable disease occurs on campus.

INFORMATION NEEDED FOR THE OFFICE OF RESIDENCE LIFE

In order to comply with an Ohio law, which went into effect July 1, 2005, any student planning on living on campus must be informed of the risk associated with and the benefits of vaccinations for meningitis and hepatitis B. In accordance with this law, we are providing you with the link to the Ohio Department of Health website (www.odh.ohio.gov) for further information.

Please note that this law does not require vaccination, nor does if require the institution to provide or pay for these vaccines. If requires only disclosure of whether or not you have been vaccinated. Your signature below will suffice as a release for the Student Health Center to be able to share the information regarding only those immunizations with the office of Residence Life, should the need arise.

Signature_____ Date_____