

**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](http://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				

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

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 – ATTACH RESULTS**

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
<b>Dtap</b> Diphtheria, Tetanus Pertussis					
<b>**Tdap</b> (required within 10 years)					
<b>**MMR – 2 doses</b> Measles, mumps, rubella <b>Required</b>					
<b>Varicella</b> Chicken Pox					
<b>Hepatitis B</b>					
<b>Hepatitis A</b>					
<b>Meningococcal</b>					
<b>HPV</b> Human Papillomavirus					
<b>Influenza</b> Most recent					
<b>IPV/OPV</b> Polio					
<b>COVID 19</b> <b>*Include copy of card</b>					

**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](http://www.odh.ohio.gov)) for further information.

Please note that this law does not require vaccination, nor does it require the institution to provide or pay for these vaccines. It 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 \_\_\_\_\_