



Student Health Form (Page 1 of 6)

All undergraduate campus-based students are required to complete the Cedarville University Student Health Form and **return it by August 1** for fall semester and January 1 for spring semester. Physical and dental exams are not required but strongly recommended. However, proof of measles immunity (rubeola) is required. As with all medical information, the confidentiality of your records will be maintained. Please see UMS Notice of Privacy Practices posted online at www.cedarville.edu/privacypractices. **If you have any questions about this form, please call University Medical Services (UMS) at 937-766-7862.**

SECTION 1: DEMOGRAPHIC INFORMATION

Student's Last Name (please print) First Name Middle Name

Social Security Number Date of Birth (month/day/year)

Home Address (number and street) City State Zip Country

Cedarville University Student ID Number Home Phone Number Cellphone Number

Sex M F Marital status Single Married Divorced Widowed

Person to Contact in Case of Emergency Relationship (parent, guardian, spouse)

Contact's Address

Contact's Phone Number

SECTION 2: STATEMENTS OF AUTHORIZATION

1. I authorize and request UMS to administer outpatient and inpatient care, including medical and surgical services, immunization, and emergency procedures as necessary, or to defer to duly licensed medical personnel when indicated, including transfer to hospitals.

I hereby state that I am capable of safely participating in vigorous physical activity offered through physical education, intramural, and intercollegiate athletics, unless otherwise noted in this Cedarville University Student Health Form.

Signature of Student Date

Signature of Parent or Puardian (IF STUDENT IS UNDER AGE 18) Date

2. I hereby acknowledge that I have received a current copy of the UMS Notice of Privacy Practices (www.cedarville.edu/privacypractices), effective April 14, 2003.

I am aware that UMS has included a provision that states it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

I understand that if I should have any questions about the UMS Notice of Privacy Practices, I can call UMS at 937-766-7862.

Signature of Student Date

Signature of Parent or Guardian (IF STUDENT IS UNDER AGE 18) Date



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Student's Name _____ Date of Birth _____

SECTION 3: RECORD OF IMMUNIZATIONS

This section must be completed by your physician OR you can attach an official copy of your immunization record. Your immunization record must have a stamp or a signature from a health care provider or must be another official form of medical documentation. For information about recommended vaccinations, visit the Centers for Disease Control website at www.cdc.gov/vaccines/recs/schedules/default.htm.

REQUIRED: PROOF OF MEASLES IMMUNITY (RUBEOLA)

Proof of measles immunity (rubeola) is required for all campus-based undergraduate students.

This is the only health requirement for Cedarville University. Measles immunity is verified by one of four ways:

- 1. You have received two doses of measles vaccine or MMR, the first after 12 months of age and the second at least 30 days after the first dose.
2. You have had the disease of measles substantiated by medical records.
3. You were born before 1957.
4. You have had a blood test to determine measles immunity (Rubeola Titer).

Tips on Getting Copies of Immunization Records

- 1. Check with your parents or family members for records of childhood immunizations.
2. Contact your family physician or pediatrician.
3. Contact the clinic or hospital where shots were given.
4. Check your passport or other travel health records for overseas trips.
5. Call your elementary, middle, or high school for copies of immunization records.

Table with 10 columns: MMR, Measles (Rubeola), Mumps, Rubella, Tetanus DPT Td Tdap, Polio, Hepatitis B, Varicella (Chickenpox), TB (Last Test). Rows include Date, OR Titer (blood test), and OR History of Disease.

Immunization for Bacterial Meningitis (Meningococcal) (Complete the History of Disease section OR the Vaccine section.)

History of Disease [] No [] Yes _____ Date
Conjugate Vaccine _____ Date
Polysaccharide Vaccine _____ Date

Name(s) and date(s) of other immunizations, including those for travel:

Signature or Stamp of Physician or Health Care Personnel

Physician's Name (please print) Address City State Zip

Signature of Physician or Physician Representative Phone Fax



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Student's Name _____ Date of Birth _____

SECTION 4: (OPTIONAL) CULTURAL INFORMATION

Cedarville recruits students from many countries and cultures throughout the world, including students who were raised on the mission field. Your culture is important to the medical staff at UMS. Please answer the following questions so UMS staff can better assist you with your health care needs.

- 1. Country of Origin (place of birth) _____ 2. How long have you lived in the United States? _____
3. Ethnic Origin (Asian, Black, Hispanic, Native American Indian, White, Other) _____ 4. What language(s) do you speak fluently? _____
5. Have you spent time on the mission field or have you lived in any other countries besides the United States? If yes, where and for how long? _____
6. What specific information would you like your health care provider to know about you with regard to your culture? _____

SECTION 5: HEALTH HISTORY

I do not have any of these health problems or any allergies.

Check each health problem that you have or have ever had.

- Acne requiring prescription medication
Anemia
Anxiety
Arthritis
Asthma
Auto-immune disorder
Back or joint problems

- Blackouts
Blindness
Cancer
Cerebral palsy
Chickenpox
Concussion
Depression
Diabetes
Ear, nose, throat problems
Eating disorder (specify): _____
Emotional/mental illness
Eye problems/disease

- Gastrointestinal problems
Head injury with loss of consciousness
Hearing loss
Heart murmur
Heart problem
Hepatitis
Hypertension (high blood pressure)
Kidney/bladder problems
Malaria
Menstrual problems
Migraines
Multiple sclerosis
Ovarian cyst

- Rheumatic fever
Seizure disorders (epilepsy)
Skin problems
Sudden death in family
Suicide attempt
Surgeries (list): _____

- Thyroid disorder
Urinary tract infection
Other _____

Explain any positive answers. _____

List all medications, vitamins, and nutritional supplements that you regularly take, with or without a prescription. _____

Height _____ Weight _____ Blood Pressure and Date Taken _____

Please list all medication allergies. _____

Please list all food allergies and all environmental allergies (Ex: hay fever, bee stings, pollen, dust, etc.). _____

SECTION 6: QUESTIONS ABOUT TUBERCULOSIS (TB)

Have you ever been diagnosed with TB? No Yes If yes, were you treated for TB? _____

Have you ever had a positive TB skin test? No Yes If yes, when? _____

If you answered "yes" to the question above, were you treated with INH or another TB drug? _____

Please comment on whether or not you completed the treatment and the dates of treatment. _____

Have you had a recent chest X-ray? No Yes If yes, when, and what were the results of the X-ray? _____

Have you ever taken the BCG vaccine? No Yes

(BCG: Bacillus Calmette-Guerin is a vaccine for TB disease that is used in many foreign countries; not recommended in the United States.)

Please circle any of the following symptoms that you currently have:

a prolonged cough that has lasted more than three weeks with sputum production, a fever with chills, night sweats, fatigue, bloody sputum, a prolonged loss of appetite, and persistent weight loss without dieting
The symptoms listed above are symptoms of TB. If you have any of the symptoms, check with your physician right away. For more information on TB, visit www.cdc.gov/nchstp/tb/faqs/qa.htm.

SECTION 7: SPECIAL MEDICAL CONDITION OR CIRCUMSTANCE

If you have a physical or mental disorder, disability, or critical medical condition, please describe. Attach additional pages if needed.



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Student's Name _____ Date of Birth _____

SECTION 8: (OPTIONAL) AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION TO PARENTS, GUARDIANS, OR PERSONAL REPRESENTATIVES

As a courtesy to you, University Medical Services (UMS) has provided this authorization form so in the event that you become ill or need assistance with your health care decisions, your permission may be given ahead of time to discuss your health care with persons you designate, such as parents, guardians, or personal representatives.

Student's Last Name (please print) _____ First Name _____ Middle Name _____

Date of Birth (month/day/year) _____

As required by the HIPAA privacy rule, UMS may not use or disclose your protected health information except as provided in the UMS Notice of Privacy Practices (www.cedarville.edu/privacypractices) without your authorization. UMS can only release your protected health information to the person(s) you designate.

Effective dates for this authorization are from now until I withdraw or graduate from Cedarville University, whichever occurs first. I understand that the information disclosed above may be re-disclosed to additional parties and is no longer protected for reasons beyond the control of UMS.

I understand I have the right to

- Revoke this authorization by sending written notice to UMS and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
• Know of any remuneration involved due to any marketing activity as allowed by this authorization and as a result of this authorization.
• Inspect a copy of patient health information being used or disclosed under federal law.
• Refuse to sign this authorization.
• Receive a copy of this authorization.
• Restrict what is disclosed with this authorization.

I hereby authorize UMS and any of its employees to use or disclose my patient health information to the following person(s): _____ (parents, guardians, or personal representatives).

Patient health information authorized to be disclosed. PLEASE INITIAL APPLICABLE STATEMENT.

_____ Standard: Any and all health information

_____ Exception: _____

For the specific purpose of (describe in detail). PLEASE INITIAL APPLICABLE STATEMENT.

_____ Standard: Involvement in my health care

_____ Exception: _____

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

Signature of Student or Student's Authorized Representative _____ Date _____

Signature of Parent or Guardian (IF STUDENT IS UNDER AGE 18) _____ Date _____

For UMS Staff Only

Authorized Signature of UMS Staff Member _____ Date _____



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ATTENTION: STUDENTS DESIRING RESIDENCE HALL HOUSING AT CEDARVILLE UNIVERSITY

Students 18 years and older may complete this form online at www.cedarville.edu/vaccinationform.

- I completed this form online. (If checked, you may leave this page blank.)
I completed this form and turned it in to the residence life office.

Student's Name _____ Date of Birth _____

SECTION 9: (REQUIRED) MENINGOCOCCAL AND HEPATITIS B VACCINATION STATUS FORM

The state of Ohio requires all institutions of higher education to have a disclosure of vaccination status on file for meningitis and hepatitis B. The law does not require students to be vaccinated but does require universities and colleges to keep a Meningococcal and Hepatitis B Vaccination Status Form on file for each student living in the residence halls.

Meningococcal (Bacterial) Meningitis

Meningococcal (bacterial) meningitis is a potentially fatal bacterial infection that causes inflammation of the membranes surrounding the brain. Symptoms of bacterial meningitis in order of frequency are: stiff neck, fever, headache, rash, extreme fatigue, nausea, vomiting, and sensitivity to light.

In 2005, a new vaccine was released for bacterial meningitis called Menactra, a conjugate vaccine that may produce lifetime immunity and is now the preferred vaccine to prevent bacterial meningitis.

Hepatitis B

Hepatitis B is a viral infection of the liver that is transmitted from the blood and body fluids of an infected person through another person's mucous membranes or broken skin, much like AIDS (HIV) is transmitted. Hepatitis B is a vaccine-preventable disease.

IF YOU ARE PLANNING TO RESIDE IN THE RESIDENCE HALLS, YOU MUST COMPLETE THE "MENINGOCOCCAL AND HEPATITIS B VACCINATION STATUS FORM" BELOW. YOU ARE NOT REQUIRED TO HAVE THE VACCINATION, BUT YOU MUST DISCLOSE YOUR VACCINATION STATUS.

I, the undersigned student (if 18 years of age or older) or parent (if student is under 18), have read and understand the information provided to me about meningococcal meningitis and hepatitis B.

I understand the benefits and risks of being vaccinated against these diseases. The information below regarding my/my student's vaccination status is accurate and is being provided in compliance with the Ohio Revised Code, Section 1713.55, (B).

Meningococcal Vaccine Received [] Yes [] No [] Yes, but not sure of date.
If yes, please list the date. _____

Hepatitis B Vaccine Received [] Yes [] No [] Yes, but not sure of dates.
If yes, please list the dates.
First Dose _____
Second Dose _____
Third Dose _____

As required by the HIPAA privacy rule, UMS may not use or disclose your protected health information except as provided in the UMS Notice of Privacy Practices (www.cedarville.edu/privacypractices) without your authorization. I hereby authorize UMS and any of its employees to use or disclose my patient health information to the following person(s), entity(s), or business associates of UMS: Cedarville University Student Life Division. Patient health information authorized to be disclosed: Information related to my meningococcal and hepatitis B vaccination status for the purpose of staying in the residence hall. For the specific purpose of: Compliance with Ohio Revised Code, Section 1713.55, (B).

Signature of Student _____ Date _____

Signature of Parent or Guardian (IF STUDENT IS UNDER AGE 18) _____ Date _____



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Student's Name _____ Date of Birth _____

SECTION 10: PRIVATE INSURANCE INFORMATION Please answer the following questions.

1. Do you have Medicaid or state children's insurance?

Do you have Medicare? [] Yes [] No Medicare number _____ Date effective through _____

Do you have Medicaid? [] Yes [] No Medicaid number _____ Date effective through _____

If you have Medicaid health insurance, please check with your Medicaid office to see what kind of health care coverage you have when you are away at college.

2. Do you have private health insurance? (UMS recommends that you keep a copy of your private health insurance card with you at all times.)

- [] No, I do not have private health insurance.
[] Yes, I do have private health insurance.

(ATTACH A COPY OF THE FRONT AND BACK OF YOUR PRIVATE INSURANCE CARD BELOW.)

Please attach a copy of the FRONT side of your private insurance card here:

Large empty box for attaching the front side of a private insurance card.

3. Does your private health insurance wish to be primary in the event that you need to use health insurance for a medical need?

[] No [] Yes

If you have private health insurance, you now have two health insurance companies. One insurance will be primary (will pay first) and the other will be secondary (will pay second). The decision as to which insurance is primary and which is secondary must be determined by your private insurance company. You can obtain this information from your private insurance company by calling the customer service number on your insurance card. To help your private insurance company in the decision process, please give them this information:

- Cedarville University Student Insurance is NOT a major medical policy.
• Cedarville University is the policyholder.
• The policy is a blanket policy.
• There is no premium, as this insurance is a benefit of tuition.
• The student insurance coordinates benefits.
• The student insurance is a primary policy which may function as a secondary policy when other insurance is available.

Attach a copy of the BACK side of your private insurance card here:

Large empty box for attaching the back side of a private insurance card.

PATIENT INSURANCE AUTHORIZATION

I hereby authorize UMS to furnish information to insurance carriers concerning my illness, condition, and treatment, and I hereby irrevocably assign to the physician/health center all payments for medical services rendered to myself or my dependents. I understand that I am financially responsible for all charges that may be charged to my student health account.

Signature of Patient _____ Date _____

Signature of Parent or Guardian (IF STUDENT IS UNDER AGE 18) _____ Date _____

Name of Insured Person _____ Insured Person's Date of Birth _____

For UMS Staff Only

Table with columns: Office, Measles Immunity (Date, RN), Men/Hep Vac Form (Yes/No), Critical Medical Conditions, Drug Allergies. Includes rows for Other Medical Conditions and Other Allergies.