CEDARVILLE UNIVERSITY

Student Health Form (Page 1 of 6)

All 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 ______ Cell phone 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 guardian **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 ______

CEDARVILLE UNIVERSITY™

Student's Name ______________________________ Date of Birth ______________________________

SECTION 3: (REQUIRED) 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. Proof of measles immunity (rubeola) is required. For information about recommended immunizations for college students, visit the American College Health Association's (ACHA) website at www.acha.org/Topics/vaccine.cfm.

INFORMATION REGARDING MEASLES (RUBEOLA) VERIFICATION

The only health requirement for Cedarville University is verification of measles (rubeola) immunity. 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.

Immunizations

This section must be completed by your physician OR you can attach an official copy of your immunization record.

	MMR	Measles (Rubeola)	Mumps	Rubella	Tetanus DPT Td Tdap	Polio	Hepatitis B	Varicella (Chickenpox)	TB (Last Test)	
Date									Date	Results
Date										
Date									Date	Results
Date										
Date										
Date										
OR Titer (blood test)										
OR History of Disease (If "Yes," include date.)										

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

History of Disease ❑ No

Conjugate Vaccine ____________________
Date

❑ Yes ____________________
Date

Polysaccharide Vaccine ____________________ ____________________
Date Date

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

____

____

Signature or stamp of physician or health care personnel

____

Name (please print) Address City State Zip

____

Physician's signature Phone Fax

CEDARVILLE UNIVERSITY

Student Health Form (Page 3 of 6)

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

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

- ❑ Acne requiring prescription medication
- ❑ Anemia
- ❑ Anorexia nervosa
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Back or joint problems
- ❑ Binge eating
- ❑ Blackouts
- ❑ Blindness
- ❑ Bulimia
- ❑ Cancer
- ❑ Cerebral palsy
- ❑ Chickenpox
- ❑ Depression
- ❑ Diabetes
- ❑ Ear, nose, throat problems
- ❑ 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
- ❑ 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.

____

____

CEDARVILLE UNIVERSITY™

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

CEDARVILLE UNIVERSITY

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.)

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. The intent of the law is to educate young adults on the risks of meningococcal disease and hepatitis B and to encourage prevention by vaccination.

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. The disease is transmitted through close, direct contact with the oral secretions of an infected person by sharing glasses or utensils, kissing, and coughing. Meningitis is rare in persons over 30 years old and is more common in the late winter and early spring.

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. For more information on Menactra, visit www.menactra.com.

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. The vaccination schedule consists of three injections: the initial immunization, the second injection one month from the first injection, and the third injection five months from the second injection for optimum immunity. In the event of disruption of the schedule, the immunizations can still be continued, but a blood titer is recommended to determine if a fourth shot is needed.

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. If you want to get the vaccinations or have questions about whether you should be vaccinated, talk with your family doctor or call University Medical Services at 937-766-7863. For more information about the new law, meningitis, and hepatitis B, visit **http://codes.ohio.gov/orc/3701.133**.

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 3701.133, (B).

Meningococcal vaccine received ❑ Yes ❑ No

If yes, please list the date. ______________________________

Hepatitis B vaccine received ❑ Yes ❑ No

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 3701.133, (B).**

____

Signature of student Date

____

Signature of parent or guardian **IF STUDENT IS UNDER AGE 18** Date

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.)

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.

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

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

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

For UMS Staff Only				
Office	**Measles Immunity**	**Men/Hep Vac Form**	**Critical Medical Conditions**	**Drug Allergies**
	Date RN App'd. ________ Ret'd. ________ Waiver ________	❑ Yes ❑ No	________ ________ ________	________ ________ ________

Other Medical Conditions	Other Allergies
________ ________	________ ________