

Mercer University
CAMPUS HEALTH CARE SERVICES
Health Information Form

3001 Mercer University Drive
Atlanta, GA 30341
Phone (678) 547-6130 Fax (678) 547-6054

Alternate Sites – Henry Co./ Douglas Co.

| | |
|--------------------------------------|-----------------------------------------|
| FOR OFFICE USE ONLY | |
| <input type="checkbox"/> Compliance | <input type="checkbox"/> Non-Compliance |
| <input type="checkbox"/> 2 MMR | <input type="checkbox"/> Chest X-ray |
| <input type="checkbox"/> IHN Therapy | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> PPD | |

Name _____ SS # _____

DOB _____ Male _____ Female _____

Address _____
Street City State Zip

Home Phone _____ Cell _____ Work _____

| | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| PLEASE MARK ALL THOSE THAT APPLY | |
| School: <input type="checkbox"/> Business <input type="checkbox"/> Education <input type="checkbox"/> ELI <input type="checkbox"/> Extended Education <input type="checkbox"/> Nursing <input type="checkbox"/> Pharmacy <input type="checkbox"/> Theology <input type="checkbox"/> Undergraduate | |
| Type of Visa: F1 ___ F2 ___ B ___ J ___ H ___ L ___ <input type="checkbox"/> Physician's Asst. _____ Year Entering _____ | |

In case of Emergency, please notify:

Name _____ Relationship to you _____

Home Phone _____ Cell _____ Work _____

| | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|
| INSURANCE INFORMATION | |
| All students are required to continue adequate health insurance coverage at all times. PLEASE ATTACH A FRONT AND BACK COPY OF YOUR HEALTH INSURANCE CARD. | |
| Insurance Company Name _____ | Group # _____ |
| Policy # _____ | Insured's DOB _____ |
| Insured's Name _____ | Relationship to You _____ |
| Insured's Employer _____ | |

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| H.I.P.A.A. Statement |
| It is the policy of Mercer University Campus Health Care Services to adhere to all Health Insurance Portability and Accountability Act (H.I.P.A.A.) Guidelines. All discussions and/or documents related to confidential patient/client health information shall be held in strict confidence. Information will only be written or electronically transmitted using the client/patient initials. Further, this information will only be shared with faculty involved in the student's education process. Client/patient discussions will be held in designated areas of the university or clinical facility. |

I have read and understand the services provided to me as a Mercer University student, and elect to participate in this program. I hereby consent to the release of my medical records or other information about my medical history to Campus Health Care Services. I also authorize payment of medical benefits to Campus Health Care Services.

Signature _____ Date _____

Health Information

Information regarding your health history is requested for your protection and to assist us in case of emergency. The information is confidential. Portions of this information may be shared with appropriate personnel or as required in scheduling referrals.

Do you have any medical problems that may affect your participation in academic programs or that may require accommodation? No ___ Yes ___

Are you currently taking any prescription medications? No ___ Yes ___ List Medications _____

Do you have allergies to food, medications, etc.? No ___ Yes ___ Please explain _____

IMMUNIZATIONS AND HEALTH SCREENING – Required for ALL STUDENTS

**To be completed and signed by a health care provider. Dates must include month, day, and year.
(Acceptable Official documents may be submitted.)**

I. Required Immunizations

- A. For students born before 1957, Rubella immunity as in IV
 B. For all other students, either (a) MMR immunity, as in I or (b) measles, mumps, and rubella immunity, as in II, III, IV.

A. MMR (Measles, Mumps, Rubella) Note: Date must be after 1970

1. ___ Dose 1 – immunized at 12 months of age or later, and (MO/DAY/YR) ___/___/___
 2. ___ Dose 2 – immunized at least 30 days after Dose 1 (MO/DAY/YR) ___/___/___

B. MEASLES Note: Date must be after March 4, 1963

1. ___ Had disease, confirmed by physician diagnosis in office record, OR (MO/DAY/YR) ___/___/___
 2. ___ Born before 1957 and therefore considered immune, OR (MO/DAY/YR) ___/___/___
 3. ___ Has laboratory evidence of immune titer (specify date and include copy of results) (MO/DAY/YR) ___/___/___
 4. ___ Immunized with live measles vaccine at 12 months or age or later, AND (MO/DAY/YR) ___/___/___
 5. ___ Immunized with second dose of live measles vaccine at least 30 days after dose 1 (MO/DAY/YR) ___/___/___

C. MUMPS Note: Date must be after April 22, 1971

1. ___ Had disease; confirmed by physician diagnosis in office record, OR (MO/DAY/YR) ___/___/___
 2. ___ Born before 1957 and therefore considered immune, OR (MO/DAY/YR) ___/___/___
 3. ___ Has laboratory evidence of immune titer (specify date and include copy of results) (MO/DAY/YR) ___/___/___
 4. ___ Immunized with vaccine at 12 months of age or later (MO/DAY/YR) ___/___/___

D. RUBELLA Note: Date must be after June 9, 1969

1. ___ Has laboratory evidence of immune titer (specify date and include copy of results) (MO/DAY/YR) ___/___/___
 2. ___ Immunized with vaccine at 12 months of age or later (MO/DAY/YR) ___/___/___
 ___ Exemption on grounds of permanent medical contraindication
 ___ Exemption on grounds of temporary medical contraindication
 a) ___ Pregnancy – expected date of confinement (MO/DAY/YR) ___/___/___
 b) ___ Other – anticipated date or end of contraindication (MO/DAY/YR) ___/___/___

II. Required Tuberculin Test (within last year)

5TU Mantoux Skin Test (PPD): Date done (MO/DAY/YR) ___/___/___ Read ___ Results ___ mm
 If positive PPD, chest x-ray date (MO/DAY/YR) ___/___/___ Results ___ (Please attach a copy of written x-ray report)
 BCG Vaccination: No ___ Yes ___ Country _____
 INH Preventive Therapy: No ___ Yes ___ Dates of Treatment: (MO/DAY/YR) ___/___/___ to ___/___/___

Required Immunizations (Required for CoPHS and Nursing Programs)

Have you had Chicken Pox? No ___ Yes ___ Approx. age ___ If no, Varicella Vaccine dates: (MO/DAY/YR) 1) ___/___/___
 2) ___/___/___
 Hepatitis B Vaccination: No ___ Yes ___
 If yes, vaccine dates: (MO/DAY/YR) 1) ___/___/___ 2) ___/___/___ 3) ___/___/___
(Nursing students are required to have a Hepatitis B Titer and attach a copy of lab)
 Tetanus Booster (within last 10 years) (MO/DAY/YR) ___/___/___
 Polio Vaccination Date (CoPHS Only) (MO/DAY/YR) ___/___/___

| | |
|---------------------------------------------------|----------------------------------------------|
| Health Care Provider _____ | |
| Address _____ | |
| | |
| _____ <i>Signature of Health Care Provider</i> | _____ <i>Health Care Provider's Phone</i> |

Signature of student

Date