![[EMU Logo]]()EMU Grad Student Health Information Form

EMU Health Services 1200 Park Rd., Harrisonburg, VA 22802

Phone: (540) 432-4308;

Upload **completed** form at: <https://emu.medicatconnect.com/>

# INSTRUCTIONS

* Please follow directions carefully and answer all questions. Health Services reserves the right to require a physical exam whenever indicated.
* **Please print neatly.**
* **Please scan and upload your COMPLETED Form (*no blank pages please)* to https://emu.medicatconnect.com/**
* **If unable to upload electronically, please return COMPLETED form including immunization record to EMU Health Services by mailing or emailing by *August 1st for fall registration* and *December 5th for spring registration* (or upon admission to graduate/seminary program). Failure to comply will result with a hold in your registration process for the following semester.**

**Admitted to:** (**Please Circle One)** CJP, MAC, Seminary, MBA, M.Ed., MA BioMedicine

**Name: EMU ID#:**

**LAST/Family FIRST/Given SECOND/Additional**

**Local mailing address:** ,

Number & Street/ Route & Box City State Zip Code

**Home Phone:** ( )\_ - **Cell phone:** ( ) - **Age: Date of Birth**(mm/dd/yyyy):

**Birth Country:**

**Pronoun: \_\_\_\_\_\_\_\_\_\_\_\_** **SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency contact:** \_\_\_ **Relationship:** \_ \_ **Phone:** (\_ \_) -\_

**Health Care Provider:** \_ \_\_ \_ \_\_\_ **Phone:** (\_ ) \_\_ \_- \_\_

**Were you enrolled at EMU prior to this admission:** □ yes □ no

**Name during prior enrollment: Departure date/year of prior enrollment:**

# HEALTH INSURANCE INFORMATION

## Please complete page 3 of this form and upload a copy of the front and back of your insurance card.

**Personal/Family History:**

Have you or any of your family ever had any of the following illnesses? If yes, please give relationship,

i.e. self, mother, father, uncle, etc.

|  |  |
| --- | --- |
| Asthma | Cancer – type: |
| Depression/anxiety/other | Diabetes |
| Heart disease | High blood pressure |
| Kidney disease | Tuberculosis |
| Any chronic illness not mentioned | Sudden death before age 50 |

**Allergies** (drug, food, etc.) **Hospitalizations/Surgeries** (reasons & dates) **Current medications taken regularly**

I fully understand that I am legally responsible for any medical expenses incurred during my enrollment at EMU. It is my responsibility to notify EMU Health Services of health/insurance changes while enrolled. By signing below I authorize release of pertinent medical information and future medical consultations with relevant EMU Departments knowing that all medical information will be kept confidential.

**Signature of student: Date:** \_\_ \_\_ \_\_ \_\_ \_\_\_ \_\_ \_\_

## EMU IMMUNIZATION RECORD

**Name:**

Last Name First Name

**EMU ID number:**

* **You can request immunizations from:**

**Date of Birth (mm/dd/yyyy):** / /

**Health care provider Your local health dept. Undergrad. College/Univ. High School/Central Office**

* **Please have a health care provider complete this form and sign it at the bottom, OR have the health care provider fax your immunization records. NOTE: If immunization records are not available, blood titer reports are sufficient.**

**TB screening at a U.S. facility -\*\*Required\*\***

**TB Screening date – Must be within one year of current enrollment: IF TB Screening is POSITIVE, complete a, b, and/or c below.**

 **/ /\_**

**RESULT: Positive / Negative**

1. PPD (Mantoux) Date Given / / diameter)

Date Read / /

Result mm induration (horizontal

1. IGRA blood test results (T-Spot, Quantiferon Gold) -- Positive / Negative -- Date / /
2. Chest x-ray - if positive IGRA blood test or ppd (attach x-ray report)
	* INH Prophylaxis: Dates: From / /

To / /

OR  Sign waiver for INH Therapy

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **VACCINE** | **DATE MM/DD/YY** | **DATE MM/DD/YY** | **DATE MM/DD/YY** | **DATE MM/DD/YY** | **DATE OF TITER&RESULT** |
| **Hep A (2 doses) Hep AB (Twinrix****-3 doses)** |  |  |  |  |  |
| **Hepatitis B series** |  |  |  |  |  |
| **MMR – measles, mumps, rubella (not required if born****before 1957)** |  |  |  |  |  |
| **Meningococcal – one must be given at age 16 or older****(or sign Waiver)** |  |  |  |  |  |
| **Polio series OPV/IPV****(circle one)** | Last date of series |  |  |  |  |
| **Covid19Vaccine(s) Include name ie:****Pfizer; Moderna; J&J** |  |  | Booster |  |  |
| **TDAP / TD****(within 10 yrs.)** |  |  |  |  |  |
| **Varicella - chicken pox (or year of disease; not required if born before 1980)** |  |  | **Date of disease:** |  |  |

**Health Care Provider:** \_

**Signature/Title Phone Number**

**Health Care Provider: PRINT NAME Fax Number**

**Date**

**Meningitis Waiver**

I have read the meningococcal disease and immunization information from the Virginia Department of Health website <http://www.vdh.state.va.us/Epidemiology/factsheets/Meningococcal.htm>and the CDC vaccine information sheet at: <http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-mening.pdf>. I have chosen not to be vaccinated.

 \_ Signature of Student Printed Name Date

**If you wish to sign a waiver for any other vaccines please go to** [**https://emu.edu/studentlife/health/docs/vaccine-waiver.pdf**](https://emu.edu/studentlife/health/docs/vaccine-waiver.pdf) **-and follow the instructions.**

**EMU HEALTH INSURANCE INFORMATION**

Student’s Name: Date of Birth: EMU ID:

* **ATTACH** a legible copy of the front & back of your current insurance card (if covered on multiple plans, please indicate which insurance is **PRIMARY** and which is **SECONDARY** coverage).
* It is recommended for students to keep a copy of their insurance card with them at all times.
* Check with your insurance provider to see what kind of health care coverage you have while attending Eastern Mennonite University (i.e. out of state, out of network, etc.).
* **Provide updated information** to EMU Health Services if you have insurance coverage changes while enrolled at EMU to prevent delays/denials with claims.
* EMU Health Services **does not accept Medicare**.

## Please check all that apply to you currently:

 I have **enrolled** for EMU Health insurance coverage.

 I have **private** health insurance; i.e. Aetna, Blue Cross/Blue Shield, Cigna, Kaiser, Optima, United, etc.

## Name of Insurance Company:

 I have **Medicaid** coverage. If yes: VA Medicaid Out-of-state Medicaid NOTE: **Virginia Medicaid is the only Medicaid accepted by EMU Health Services.**

 I do not have health insurance and expect to pay the “Self-pay” charge at the time of service.

**Patient Insurance Authorization:**

I hereby authorize EMU to furnish information to insurance carriers concerning my illness, condition, and treatment, and I hereby irrevocably assign to EMU Health Services 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

Name of Policyholder/Subscriber Policyholder/Subscriber’s Birthdate