Health Information Form

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

Centers: Atlanta, Douglas, Henry, Newnan

Name ____________________ Student ID # ____________________

DOB ____________________ Male ________ Female ________ Email ____________________

Address ____
Street *City* *State* *Zip*

Cell Phone ____________________ Home ____________________ Work ____________________

PLEASE MARK ALL THOSE THAT APPLY

School: ☐ Business ☐ Education ☐ ELI ☐ Extended Education ☐ Nursing ☐ Pharmacy ☐ Theology ☐ Undergraduate
☐ Public Health ☐ Penfield ☐ Physician's Asst.

In case of Emergency, please notify:

Name ____________________ Relationship to you ____________________

Home Phone ____________________ Cell ____________________ Work ____________________

INSURANCE INFORMATION

Students are required to maintain health insurance coverage. **PLEASE ATTACH A FRONT/BACK COPY OF HEALTH INSURANCE CARD**

Insurance Company Name ____________________
Policy # ____________________ Group # ____________________
Insured's Name ____________________ Insured's DOB ____________________
Insured's Employer ____________________ Relationship to You ____________________

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 I – 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, Varicellla 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 ______________________________
____

______________________________ Signature of Health Care Provider
______________________________ Health Care Provider's Phone

______________________________ Signature of student
______________________________ Date