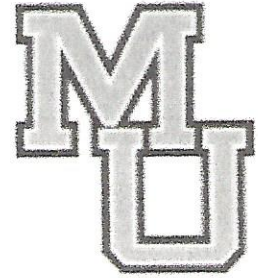


Health Information Form



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 _____ Group # _____
Policy # _____ 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 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 of 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 _____	
Signature of Health Care Provider	Health Care Provider's Phone _____

 Signature of student

 Date