

**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 _____	

H.I.P.P.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.P.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 (CoPHSOnly) (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