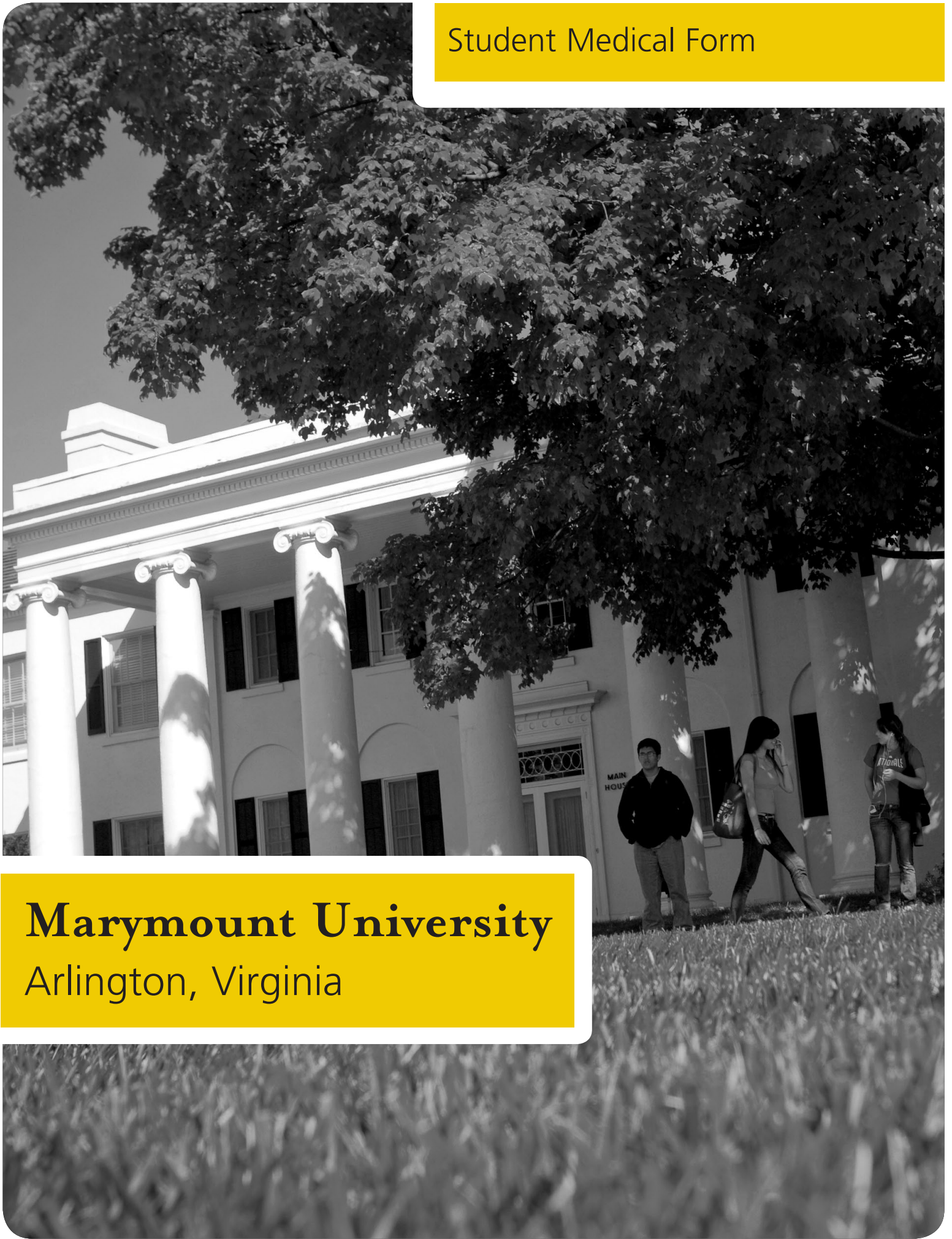


Student Medical Form



Marymount University

Arlington, Virginia



MARYMOUNT UNIVERSITY

Student Health Center

Dear Marymount University Student,

Congratulations on your acceptance to Marymount and welcome from all of us at the Student Health Center! We are committed to providing exemplary health care and assisting you in maintaining your good health.

We need some information about your health to meet the requirements of both the Commonwealth of Virginia and the University. Please review the enclosed Student Medical Form with your health care provider and complete all relevant parts, as follows:

Part I - to be filled out by all undergraduate students enrolling for the fall and/or spring semester(s), and those graduate students who will reside in University housing, both on and off campus.

Part II - to be filled out by the parent or guardian of any student under age 18.

Part III - to be filled out by the health care provider of all undergraduate students and those graduate students who will reside in University housing, both on and off campus.

Part IV - to be filled out by the health care provider of all undergraduate and graduate students who will reside in Marymount University housing, both on and off campus; School of Health Professions students; and student-athletes.

Tuberculosis Screening Form - to be filled out by the health care provider of all undergraduate students and those graduate students who will reside in Marymount University housing, both on and off campus.

Students residing in Marymount University on- and off-campus housing and student-athletes who are receiving treatment for a medical condition should also have their health care provider document this on *Part IV*. The Student Health Center can assist with follow-up care. Please note all prescription drugs you take on a regular basis. Health Center staff can administer allergy shots to those on- and off-campus resident students who require the service. However, the student must provide the serum and specific physician instructions.

The required immunizations for *Part III* are

- *Tetanus/Diphtheria (Td)* - date must be within the last 10 years.
- *Measles, Mumps, and Rubella (MMR)* - two dates are required, but persons born prior to 1957 are exempt. Persons born in 1957 and after are required to document this immunization. If they cannot, a titer (blood test) will fulfill this requirement. If you have had any of these childhood illnesses, simply record the dates in the appropriate spaces.
- *Polio* - persons born prior to 1957 are exempt. Persons born in 1957 and after are required to document this immunization series.

The School of Health Professions may have additional requirements. We advise that students enrolled in Health Professions programs contact the School at (703) 284-1580 for specific information.

Marymount University encourages students to consider vaccination against meningococcal disease and receive the Hepatitis B series of vaccinations. Informational brochures on these vaccines and on a wide array of health-related topics are available at the Student Health Center.

Please visit the Student Health Center at any time. We look forward to meeting you!



MARYMOUNT UNIVERSITY

Student Medical Form

Student Health Center · 2807 N. Glebe Road, Arlington, Virginia 22207-4299 · Phone: (703) 284-1610 · Fax: (703) 284-3816

The University's medical form policy complies with the standards of the Commonwealth of Virginia.
Failure to complete the form may result in a registration delay.

Date _____

Please type or print.

PART I

TO BE COMPLETED BY THE STUDENT

Name _____
Last/Family/Surname First/Given/Personal Middle Maiden

PERMANENT HOME ADDRESS

Number and Street _____ Apt. _____

City _____ State _____ ZIP _____ Country _____

() _____ () _____
Phone Cell

E-mail _____

Male Female Birthdate _____

Entering semester: Fall Spring Summer 20_____

Health Insurance Company _____

Policy # _____ Group # _____

Emergency Contact Person _____

Daytime Phone () _____

Illnesses or conditions for which you are undergoing treatment _____

Medications you are currently taking _____

Food, medicine, and/or environmental substances to which you are allergic _____

Tobacco use: Yes No Alcohol Use: Yes No

Have you received treatment, been hospitalized, or received counseling for an injury, illness, or emotional problem? Yes No

If yes, explain below.

Student Signature _____

CURRENT ADDRESS (IF DIFFERENT FROM PERMANENT ADDRESS)

Number and Street _____ Apt. _____

City _____ State _____ ZIP _____ Country _____

() _____ () _____
Phone Cell

MU Student # _____

Birthplace _____

Entering status: Commuter Student Resident Student

Address _____

Subscriber Name _____

Relationship to Student _____

Evening and Weekend Phone () _____

PART II – PERMISSION TO TREAT

TO BE COMPLETED BY PARENT/GUARDIAN OF STUDENT UNDER AGE 18

I, _____,
Print Name and Relationship to Student

as the adult responsible for the above-named student, give the Student Health Center permission to treat him/her.

Signature of Parent or Guardian

Detach and return completed forms to: Student Health Center, Marymount University, 2807 N. Glebe Road, Arlington, VA 22207-4299.

Name _____

Date of Birth _____

PART III-IMMUNIZATION RECORD

Students born prior to 1957 must document Tetanus/Diphtheria (Td) and complete the Tuberculosis Screening Form on the next page. Students born in 1957 and after must document Td, MMR, and Polio, and complete the Tuberculosis Screening Form. This section is to be completed by an examining physician/health care provider.

Tetanus/Diphtheria (Td) ____/____/____ MM DD YY (WITHIN LAST 10 YEARS)					
Polio (OPV/IPV) Completed: ____/____/____ MM DD YY			Meningitis (recommended) ____/____/____ MM DD YY		
Measles Date of illness: ____/____/____ MM DD YY	Live Virus Vaccine? Yes___ No___	Serologic Confirmation of Immunity ____/____/____ MM DD YY	Mumps Date of illness: ____/____/____ MM DD YY	Live Virus Vaccine? Yes___ No___	Serologic Confirmation of Immunity ____/____/____ MM DD YY
Rubella Date of illness: ____/____/____ MM DD YY	Live Virus Vaccine? Yes ___ No ___	Serologic Confirmation of Immunity ____/____/____ MM DD YY	Measles, Mumps, Rubella (MMR)	I. _____ ____/____/____ MM DD YY	2. _____ ____/____/____ MM DD YY
Hepatitis B	I. _____ ____/____/____ MM DD YY	2. _____ ____/____/____ MM DD YY	3. _____ ____/____/____ MM DD YY	Varicella Date of illness: ____/____/____ MM DD YY	Vaccine ____/____/____ MM DD YY

PART IV

THIS PART APPLIES TO ALL STUDENTS WHO RESIDE IN MARYMOUNT UNIVERSITY HOUSING, BOTH ON AND OFF CAMPUS; SCHOOL OF HEALTH PROFESSIONS STUDENTS; AND STUDENT-ATHLETES. IT IS TO BE COMPLETED BY AN EXAMINING PHYSICIAN/HEALTH CARE PROVIDER.

Are there abnormalities of the following systems? Describe fully on separate sheet if necessary.

- HEAD, EARS, NOSE and THROAT Yes No
- RESPIRATORY Yes No
- CARDIOVASCULAR Yes No
- HERNIA Yes No
- EYES Yes No
- GENITOURINARY Yes No
- MUSCULOSKELETAL Yes No
- METABOLIC/ENDOCRINE Yes No
- NEUROPSYCHIATRIC Yes No
- SKIN Yes No
- TEETH Yes No

Hb/HCT _____

URINALYSIS _____

GLUCOSE _____

ALBUMIN _____

MICROSCOPIC ANALYSIS _____

Ht _____ Wt _____ B/P _____

CORRECTED VISION _____

RIGHT 20/____ LEFT 20/ _____

Is there loss or serious impairment of any organ function? Yes No

Do you recommend limitation of physical activity for any reason? Yes No

If the student is under treatment for any medical or emotional condition, describe the condition and treatment on a separate sheet. Please include specific recommendations for care of the student.

Physician's Name (Print)

Physician's Signature

Address (Print)

Phone #

TUBERCULOSIS SCREENING

COMPLETION OF THIS FORM IS REQUIRED OF ALL UNDERGRADUATE STUDENTS AND THOSE GRADUATE STUDENTS WHO WILL RESIDE IN MARYMOUNT UNIVERSITY HOUSING, BOTH ON AND OFF CAMPUS. IT IS TO BE COMPLETED BY AN EXAMINING PHYSICIAN/HEALTH CARE PROVIDER.

Name: _____

Date of Birth: _____

1. Does the student have signs/symptoms of active TB disease? Yes No

If NO, proceed to question 2.

If YES, proceed with additional evaluation to exclude active TB disease; administer tuberculin skin test, chest X-ray, and sputum evaluation, as indicated.

2. Is the student a member of a high-risk group or is the student entering the health professions? Yes No

If NO, proceed to question 3.

If YES, administer tuberculin skin test (Mantoux only. A history of BCG should not preclude testing of a member of a high-risk group. If PPD is not administered, a chest X-ray is required. See (B) below to record results.)

3. Has the student lived or traveled (spent six weeks or more) in countries where TB is endemic? Yes No

If NO to #1, 2, and 3 – PPD and chest X-ray are not required.

If YES to #1, 2, or 3 – student should undergo tuberculin skin test or chest X-ray.

PLEASE USE THIS SPACE TO DOCUMENT TUBERCULIN SKIN TESTING AND/OR CHEST RADIOGRAPHY
(based on assessment of criteria outlined above)

A. Tuberculin Skin Test (to be read in 48 to 72 hours)

Date given: ____/____/____ Date Read: ____/____/____ Result: ____ mm

(Record actual mm of induration, transverse diameter; if no induration, write "0")

INTERPRETATION (based on mm of induration and risk factors) Positive Negative

B. Chest X-ray (required if PPD is positive or patient is at risk for disease)

Date of chest X-ray: ____/____/____ Result: Normal Abnormal

Health Care Provider (signature required for validation of form)

Name: _____ Address: _____

Signature: _____ Phone #: _____ Date: ____/____/____

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2807 N. Glebe Road
Arlington, VA 22207-4299
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admissions@marymount.edu

www.marymount.edu