Welcome to
MARYMOUNT UNIVERSITY!

All students are required to complete the Student Medical Form. This form must be returned to the Student Health Center by August 1st for the fall semester and January 1st for the spring semester. This medical form is separate and in addition to any department specific requirements. A registration block and $100 fee may result, if all requirements are not met by the first day of classes. To ensure accuracy, records must be in English. Please note, many vaccination and titer services are offered in the Student Health Center. Please contact us for additional information or to schedule an appointment.

Marymount University requires all full-time students to carry adequate health insurance. Full-time is defined as 12 credits per semester for undergraduates and 9 credits per semester for graduate students. At the start of each academic year, students will automatically be billed for the Marymount sponsored health insurance plan, unless proof of other insurance is provided by submission of an online insurance waiver.

This insurance waiver is separate from the Student Medical Form and can be found online on our website at www.marymount.edu/Student-Life/Health-Wellness/Student-Health-Center, or by visiting www.uhcr.com/marymountu. If no action is taken and a waiver is not received by the current term’s waiver deadlines, the student will be assessed a fee for the premium. For current year deadlines or for questions regarding insurance and waivers, please visit the Student Health Center website, or call our office at (703) 284-1610.
Please ensure all parts of this form are completed before submitting to the Student Health Center:

- General Information and Proof of Insurance
- Required Immunizations
- Health History

Submit completed Student Medical Form via mail, fax, email, or in person to the Student Health Center.

**PART 1. PERSONAL INFORMATION – TO BE COMPLETED BY ALL STUDENTS, PLEASE PRINT LEGIBLY**

<table>
<thead>
<tr>
<th>Last name:</th>
<th>First name:</th>
<th>Student ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Address:</td>
<td></td>
<td>Resident</td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
<td>Zip Code:</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>Home Phone:</td>
<td>Cell Phone:</td>
</tr>
</tbody>
</table>

**PART 2. EMERGENCY CONTACT INFORMATION – TO BE COMPLETED BY ALL STUDENTS**

In the event of an emergency, I give the Student Health Center permission to contact (Student initial to give consent __________):

Name: __________________________ Relationship: ______________________

Home Phone: __________________________ Cell Phone: ______________________

**PART 2a. MINOR CONSENT – ONLY IF STUDENT IS UNDER 18 YEARS AT TIME OF ENROLLMENT**

Parental permission or the consent of a legal guardian must be obtained to provide medical care to minors. To avoid delays in treatment in the event of illness or accident, please obtain the signature of a parent/legal guardian if you are under 18 years of age at the time of enrollment.

I hereby authorize the staff of Marymount University Student Health Center to assess, test, administer vaccines, and if necessary, treat my minor or dependent.

Signature of Parent or Guardian: ___________________________________________ Date: ______________________

Printed Name of Parent or Guardian: __________________________ Relationship: ______________________

**PART 3. HEALTH INSURANCE INFORMATION – TO BE COMPLETED BY ALL STUDENTS**

All full time students are required to carry health insurance while attending Marymount University.

Please Note: If your healthcare coverage is provided by a health maintenance organization or managed care program, determine what coverage is available while your student is out of network and ensure that your student has coverage in the Northern Virginia region for both primary and emergency care.

**ALL students must do one of the following:**

ATTACH a copy of insurance card (FRONT AND BACK) to this form OR

☐ CHECK BOX if enrolling in the MU Insurance Plan
PART 4. TUBERCULOSIS SCREENING – TO BE COMPLETED BY A HEALTHCARE PROVIDER FOR ALL STUDENTS

The following tuberculosis (TB) screening questions are required for ALL students. Refer to below list of countries for Questions 1 and 2.

1. Were you born in a country where tuberculosis is endemic AND did you arrive in the U.S. within the last 5 years? □ Yes □ No
   Date arrived in or intend to arrive in U.S.: ___________________ Country: ___________________

2. Have you traveled in countries where tuberculosis is endemic for 3 consecutive months or more within the last 5 years? □ Yes □ No
   Date of travel in last 5 years: ___________________ Length of stay: ___________________
   Country(ies): ____________________________________________

3. Have you had close contact with anyone who is/was sick with tuberculosis? □ Yes □ No

4. Do you have any medical conditions such as chronic renal failure, leukemia, or lymphoma, HIV infection or any other immunosuppressive disorder? □ Yes □ No

5. Do you have any symptoms of active tuberculosis such as: cough lasting 3+ weeks, night sweats, fever, unexplained weight loss and fatigue? □ Yes □ No

6. Have you resided in, volunteered, or worked in a high-risk setting such as prisons, nursing homes, hospitals, or homeless shelters? □ Yes □ No

Healthcare Provider Name ____________________________  Healthcare Provider Signature ____________________________ Date _________

If answers to ALL the above questions are NO, no TB testing or chest x-ray is required; go to part 6.

If the answer is YES TO ANY of the above questions, Marymount University requires your healthcare provider to complete Part 5 on the next page (tuberculosis test).

List of Countries for Questions 1 and 2:

Afghanistan
Algeria
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cameroon
Cape Verde
Central African Republic
Chad
China
Columbia
Comoros
Congo
Cote d’Ivoire

Croatia
Democratic People’s Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Japan
Kazakhstan
Kenia
Kiribati
Kuwait
Kyrgyzstan
Lao People’s Democratic Republic
Latvia
Lesoto
Liberia
Libyan Arab Jamahirya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nepal
Nicaragua
Niger
Nigeria
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principles
Senegal
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Thailand
The Former Yugoslav Republic of Macedonia
Timor-Leste
Togo
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (The Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe
PART 5. TUBERCULOSIS TEST – IF REQUIRED BY PART 4, TO BE COMPLETED BY A HEALTHCARE PROVIDER

If test is required, it must be performed within 6 months from the first day of classes at Marymount.

Has patient ever had a positive tuberculin skin test or blood test? □ Yes □ No

If No: Complete Section A. If Yes: Date: _________ Result: _________ complete Section B & C

Has patient ever had BCG*? □ Yes □ No

If Yes: Consider IGRA if possible.

*Students who have had BCG are still required to have a TB test

Section A: TUBERCULIN TEST – (Skin test OR blood test)

<table>
<thead>
<tr>
<th>Type</th>
<th>Date Placed</th>
<th>Date Read</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin Test</td>
<td></td>
<td></td>
<td>______</td>
</tr>
<tr>
<td>Blood Test</td>
<td></td>
<td></td>
<td>______</td>
</tr>
</tbody>
</table>

Blood Test: Immunoassay blood test (IGRA)

1. Date: ______ /______ /______  2. Result: □ Negative □ Positive

Section B: Chest X-Ray – is required if TB test is positive or if history of positive TB test and no chest x-ray report.

A copy of the chest x-ray report and/or documentation of treatment must accompany this form.

Date of Chest X-Ray: ______ /______ /______  Result: □ Normal □ Abnormal

Section C: Treatment for TB or LTBI

Documentation of treatment must accompany this form.

Date treatment started: ______ /______ /______  Date treatment completed: ______ /______ /______

Name of medication: ________________________________________________

Healthcare Provider Name                                                                 Healthcare Provider Signature

PART 6. REQUIRED IMMUNIZATIONS — TO BE COMPLETED BY A HEALTHCARE PROVIDER WHO MUST ALSO COMPLETE

AND SIGN PART 8 OR OFFICIAL OUTSIDE RECORDS MAY BE SUBMITTED

Tetanus-Diptheria: Booster must have been given within the past 10 years

Date: ______ /______ /______ (Tdap) OR Date: ______ /______ /______ (Td)

Measles, Mumps, Rubella (MMR)

1) Date: ______ /______ /______  2) Date: ______ /______ /______

2 doses required at least 1 month apart. First dose must be given on or after one year of age; and after 1971 for combined MMR vaccine or after 1967 for individual doses

OR ALL 3 OF THESE CRITERIA ARE MET:

Measles (Rubeola) 1) Date: ______ /______ /______  2) Date: ______ /______ /______

Mumps 1) Date: ______ /______ /______  2) Date: ______ /______ /______

Rubella (German Measles) 1) Date: ______ /______ /______  2) Date: ______ /______ /______

OR □ copy of titer lab work indicating positive immunity must accompany this form
### Hepatitis B (HBV)

Must receive all three doses at appropriately spaced intervals to be considered fully immunized

1) Date: ______ /______ /______  
2) Date: ______ /______ /______  
3) Date: ______ /______ /______

CHECK ONE:  
- [ ] Hepatitis B  
- [ ] Twinrix

OR [ ] copy of titer lab work indicating **positive** immunity must accompany this form

OR [ ] signed waiver on pg. 7 of form

### Meningococcal (Meningitis)

Date: ______ /______ /______ Administered Between the ages of 16 and 21

- [ ] OR signed waiver on pg. 7 of form
- [ ] OR over 22 years of age

### Additional requirement for students 17 and under

**Polio**

Date __/__/___ series completion

- [ ] OR copy of titer lab work indicating positive immunity must accompany form

### Varicella: (Chicken Pox)

1) Date: ______ /______ /______  
2) Date: ______ /______ /______

### Human Papilloma Virus: (HPV)

1) Date: ______ /______ /______  
2) Date: ______ /______ /______  
3) Date: ______ /______ /______

CHECK ONE:  
- [ ] Gardasil
- [ ] Cervarix

### Hepatitis A (If Twinrix, see Part 6, Hepatitis B)

1) Date: ______ /______ /______  
2) Date: ______ /______ /______

### Part 7: Recommended Immunizations — To be completed by a healthcare provider who must also complete and sign Part 8 or official outside records may be submitted

### Varicella: (Chicken Pox)

1) Date: ______ /______ /______  
2) Date: ______ /______ /______

### Human Papilloma Virus: (HPV)

1) Date: ______ /______ /______  
2) Date: ______ /______ /______  
3) Date: ______ /______ /______

CHECK ONE:  
- [ ] Gardasil
- [ ] Cervarix

### Hepatitis A (If Twinrix, see Part 6, Hepatitis B)

1) Date: ______ /______ /______  
2) Date: ______ /______ /______

### Part 8: Healthcare Provider Information and Signature, All Information Required

- [ ] Transcribed Records  
- [ ] Administered Vaccine(s)

Printed Name: __________________________ Title: __________________________

Name of Practice or Clinic: __________________________

Address: __________________________________________

Phone: __________________________

Healthcare Provider Signature: __________________________ Date: __________________________
WAIVER OF IMMUNIZATION AGAINST HEPATITIS B DISEASE

Hepatitis B is a serious liver disease caused by the Hepatitis B virus (HBV). HBV infection can affect people of all ages and lead to liver disease. The virus is found in the blood and body fluids of infected people; it is most often spread among adults through sexual contact or by sharing needles and other drug paraphernalia with an infected person. HBV can also be spread in households from an HBV-infected person or by passage of the virus from an HBV-infected mother to her infant during birth. Hepatitis B can be a silent disease, often infecting many people without making them feel sick. Unfortunately, 30 percent of those infected with HBV are not aware that they are carriers and can infect others. Hepatitis B symptoms may include loss of appetite, fatigue, stomachache, nausea and vomiting, yellowing of the whites of the eyes (jaundice), and/or joint pain. Vaccination can help prevent people from contracting Hepatitis B. The HBV vaccine is 96 percent effective following a series of three shots over a six-month period. The most common side effect of the vaccine is soreness at the injection site. Vaccine recipients cannot get the disease from the vaccine.

I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at any time. I have received and reviewed the information regarding Hepatitis B and the availability and effectiveness of the Hepatitis B vaccine. I have chosen not to be vaccinated (or I am unable to provide current vaccination records) against Hepatitis B.

___________________________________________________________________________

Student Signature                                                                                                                       Date

___________________________________________________________________________

If student is a minor, signature of parent/guardian                                                                                                     Date

WAIVER OF IMMUNIZATION AGAINST MENINGOCOCCAL DISEASE

Meningitis is an inflammation of the linings of the brain and spinal cord, it is caused by bacteria called Neisseria meningitidis. The bacteria are transmitted through air-borne droplets of respiratory secretions and by direct contact with infected persons. Although bacterial meningitis occurs rarely and sporadically throughout the year, increased outbreaks occur among college students, especially those who live in residence halls. Early symptoms of meningococcal disease include fever, severe headache, stiff neck, rashes, and exhaustion. If not treated early, meningitis can lead to severe and permanent disabilities or even death. A vaccine is available that protects against four strains of the bacteria that cause meningitis in the United States: types A, C, Y and W-135. These types account for nearly two-thirds of meningitis cases among college students. The vaccine is safe, with mild and infrequent side effects, such as redness and pain at the injection site lasting up to two days. The vaccine is 85 to 100 percent effective.

I have received and reviewed the information regarding meningococcal disease and the availability and effectiveness of the meningococcal vaccine. If in the future I want to be vaccinated with meningococcal vaccine, I can receive the vaccination at any time. I have chosen not to be vaccinated against meningococcal disease.

___________________________________________________________________________

Student Signature                                                                                                                       Date

___________________________________________________________________________

If student is a minor, signature of parent/guardian                                                                                                     Date