Any student enrolled in an undergraduate program or any student who resides in Marymount sponsored housing is required to complete the Student Medical Form. This form must be returned to the Student Health Center by August 1st for the Fall term or January 1st for the Spring term. A registration block and $100 fee may result if all requirements are not met. 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 undergraduate and 9 credits per semester for graduate students. At the start of each academic year, students will automatically be enrolled in the Marymount sponsored health insurance unless proof of other insurance is provided by submission of an online insurance waiver. This Insurance Waiver is separate from the Medical Form and can be found online at www.uhcsr.com/marymountu. If no action is taken and a waiver is not received by the current term’s waiver deadlines, the student will be enrolled and assessed a fee for the premium. For current year deadlines or for questions regarding insurance and waivers, please visit the Student Health Center website at www.marymount.edu 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, or email to the Student Health Center (see above for contacts).

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

<table>
<thead>
<tr>
<th>Last name:</th>
<th>First name:</th>
<th>Student ID:</th>
</tr>
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| U.S. Address: | |  |
|---------------|---------------|
| ☐ Resident ☐ Commuter |

<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>Zip Code:</th>
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<table>
<thead>
<tr>
<th>Date of Birth:</th>
<th>Home Phone:</th>
<th>Cell Phone:</th>
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### 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 ______________________________________________________

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:

PART 5. TUBERCULOSIS TEST – TO BE COMPLETED BY A HEALTHCARE PROVIDER IF REQUIRED BY PART 4

If skin test is required, please administer or provide documentation of a skin test performed within 12 months prior to form’s deadline.

Tuberculin Test (Skin test OR blood test)

Skin Test - Date Placed: ______ /______ /______ Date Read: ______ /______ /______ Result: _________mm

OR

Blood Test - Immunoassay blood test (IGRA) Date: ______ /______ /______ Result (circle): Negative  Positive

**If TB test is positive or if there is a history of positive TB test and no chest x-ray:

Date of Chest X-Ray (within last 12 months): ______ /______ /______ Result (circle): Normal  Abnormal

OR

Documented INH therapy - Date treatment started: ______ /______ /______ Date treatment completed: ______ /______ /______

________________________________________________________________________________________

Healthcare Provider Name  Healthcare Provider Signature

PART 6. IMMUNIZATIONS – TO BE COMPLETED FOR ALL STUDENTS BY A HEALTHCARE PROVIDER OR OFFICIAL OUTSIDE RECORDS MAY BE SUBMITTED (INCLUDING TITER LAB WORK).

REQUIRED

Polio
Attached lab report showing positive immunity
-OR-
1) Date: ______ /______ /______  2) Date: ______ /______ /______  3) Date: ______ /______ /______

Tetanus-Diptheria given within last 10 years -OR- Tetanus/Diptheria/Pertussis given within last 10 years.
1) Date: ______ /______ /______  2) Date: ______ /______ /______

Measles, Mumps, Rubella (MMR) 2 doses at least 1 month apart
1) Date: ______ /______ /______  2) Date: ______ /______ /______

Meningoccocal (Meningitis) (or waiver)
Date: ______ /______ /______

Hepatitis B (HBV) (or waiver)
1) Date: ______ /______ /______  2) Date: ______ /______ /______  3) Date: ______ /______ /______

Given at least 4 weeks after dose 1  Given at least 16 weeks after dose 1, 8 weeks after dose 2

STRONGLY RECOMMENDED

Hepatitis A If Twinrix, please notate
1) Date: ______ /______ /______  2) Date: ______ /______ /______

Varicella (chicken pox) or notate if listing date of disease
1) Date: ______ /______ /______  2) Date: ______ /______ /______  Given at least 30 days after dose 1

Human Papillomavirus (HPV)
1) Date: ______ /______ /______  2) Date: ______ /______ /______  3) Date: ______ /______ /______

________________________________________________________________________________________

Healthcare Provider Name  Healthcare Provider Signature
PART 7. MEDICAL HISTORY - TO BE COMPLETED BY ALL STUDENTS

Height ____________  Weight ____________

PAST/CURRENT PERSONAL MEDICAL HISTORY: HAVE YOU EVER HAD ANY OF THE FOLLOWING:

HEART/LUNGS:
- Asthma
- Heart Disease
- Heart Murmur
- High Blood Pressure
- High Cholesterol

ENDOCRINE:
- Adrenal Disorders
- Diabetes
- Polycystic Ovary Syndrome (PCOS)
- Thyroid Disorder

KIDNEY:
- Chronic Kidney or Bladder Disease
- Kidney Stones

EARS/EYES/NOSE/THROAT
- Chronic Sinus Infections
- Eye Disorders (other than glasses or contacts)
- Hearing Loss
- Nasal Allergies/Hayfever

STOMACH/BOWEL
- Celiac Disease
- Irritable Bowel Syndrome
- Ulcerative Colitis/Chron’s
- Other Liver, Stomach, or Bowel Disease

NEUROLOGICAL
- Concussions
- Convulsions/Seizures
- Migraines/Severe Headaches

MENTAL HEALTH
- ADHD/ADD
- Anorexia (Eating Disorder)
- Bulimia (Eating Disorder)
- Depression
- Other Mental Health Problems

SKIN
- Eczema
- Psoriasis
- Hives

STUDS
- Chlamydia
- Genital Herpes
- Genital Warts
- Gonorrhea
- HPV
- Other STD

ORDOPEDICS
- Arthritis
- Fractures/Broken Bones

ORTHOEDICS
- Appendectomy
- Adenoidectomy
- Ear Tubes
- Knee ACL Repair
- Splenectomy
- Tonsillectomy
- Other Prior Surgeries

SOCIAL HISTORY
- Do you smoke?
- Do you drink alcohol?
- Do you exercise regularly?
- Do you take recreational drugs?

OTHER HISTORY
- Previous Hospitalizations

ALLERGY TO:  (Circle Yes or No. If yes, please list.)  Does student need to carry an EpiPen?  Yes  No

Medication:  Yes  No

Insect bites/Bee stings:  Yes  No

Foods:  Yes  No

Other (including environmental):  Please explain

CURRENT MEDICATIONS: Please list any prescription and over the counter medications, including birth control pills.

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☐ None

Address (printed or stamped)
WAIVER OF IMMUNIZATION - HEPATITIS B

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 and 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 of HBV-infected persons 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 might 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 95 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 Hepatitis B vaccine, I can receive the vaccination series at anytime. 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

If student is a minor, signature of parent/guardian

WAIVER OF IMMUNIZATION - MENINGOCOCAL (MENINGITIS)

Meningitis is an inflammation of the linings of the brain and spinal cord. It is caused by bacteria called Neisseria meningitis. 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 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 99 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 anytime. I have chosen not to be vaccinated against meningococcal disease.

Student Signature

If student is a minor, signature of parent/guardian

RELIGIOUS EXEMPTION

Religious exemption for immunizations is allowed if the responsible person objects in good faith and in writing that the immunizations violate his/her religious beliefs. The Religious Exemption Form can be obtained via our website at www.marymount.edu or by visiting the Student Health Center offices. Medical exemption is allowed if a physician provides a detailed letter indicating that immunizations are medically inadvisable. The exemption forms and letters are subject to Medical Form submission deadlines.