Student Health Form

Marymount University
Arlington, Virginia
Dear Marymount University Student,

Congratulations on your acceptance to Marymount University 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 Health Form with your health care provider and complete all relevant pages:

**PAGE ONE:** to be completed by all undergraduate students and those graduate students who will reside in Marymount University housing. **This must be completed by the student.**

**PAGE TWO:** to be completed by the health care provider for all undergraduate students and those graduate students who will reside in Marymount University housing. **This is to be completed by the health care provider and signed at the bottom.**

The required immunizations for Page Two are as follows:

- Students born **prior** to 1957 must document
  - Tetanus/Diphtheria/Pertussis (Td or Tdap) – within the last ten years
- Students born **after** 1957 must document
  - Tetanus/Diphtheria/Pertussis (Td/Tdap) – within the last ten years
  - Measles, Mumps, Rubella (MMR) – two dates required
  - Polio – date of completed series

Antibody Titer s can fulfill the immunization requirements. Please provide the results of titers with this form for the Student Health Center to review.

**PAGE THREE:** to be completed by the health care provider for all undergraduate resident students and those graduate students who will reside in Marymount University housing, student athletes, and Malek School of Health Professions students. **This is to be completed by the health care provider and signed at the bottom.**

Students residing in Marymount University housing and student athletes who are receiving treatment for a medical condition should also have their health care provider document this on Page Three. List all prescription drugs you take on a regular basis. The Health Center staff can administer allergy shots to resident students who require the service.

The Malek School of Health Professions provides its students with its own School's additional requirements. Students enrolled in the School must refer to this specific information. Please see the permission section on the bottom of Page Three that allows the Student Health Center to share this completed form with the Malek School of Health Professions for clinical placement requirements.

Marymount University encourages vaccinations against varicella, meningococcal disease, Hepatitis A and B series, and human papillomavirus. 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

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. Please print.

PAGE ONE
TO BE COMPLETED BY THE STUDENT (REQUIRED)

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

PERMANENT HOME ADDRESS

Number and Street  Apt.
City                                                State         ZIP                  Country          
  (        )  _________________________   (        )  _______________ __________
Phone     Cell

CURRENT ADDRESS (IF DIFFERENT FROM PERMANENT ADDRESS)

Number and Street  Apt.
City                                                State         ZIP                  Country          
  (        )  _________________________   (        )  _______________ __________
Phone     Cell

Health Insurance Company      Address

Policy #      Group # Subscriber Name

Emergency Contact Person  ______________________________________________________________________________________________________________________________________
Name       Relationship to Student
Daytime Phone (       )  _____________________________________________________  Evening and Weekend 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 concern?  ☐ Yes  ☐ No

If yes, explain below and attach documentation.

_____________________________________________________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________________________________________________

Student Signature  __________________________________________________________ Date  ____________________________________________________________________________

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

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

______________________________
Print Name and Relationship to Student

______________________________
Signature of Parent or Guardian

Return completed forms to Student Health Center, Marymount University, 2807 N. Glebe Road, Arlington, VA 22207-4299 | FAX (703) 284-3816
MARYMOUNT UNIVERSITY STUDENT HEALTH FORM

Name ___________________________ Student ID ___________ Date of Birth ___________

PAGE TWO

Must be completed by the health care provider for all undergraduate students, all students who reside in campus housing, student athletes, and all Malek School of Health Professions students. The health care provider’s SIGNATURE is required at the bottom of the page in order for the form to be validated.

IMMUNIZATION RECORD

Students born prior to 1957 must document Tetanus/Diphtheria/Pertussis (Td or Tdap) within the last ten years and complete the Tuberculosis Screening Form. Students born in 1957 and after must document Tetanus/Diphtheria/Pertussis (Td or Tdap) within the last ten years, two doses of MMR, and Polio, and complete the Tuberculosis Screening Form. This section is to be completed by an examining physician/health care provider.

<table>
<thead>
<tr>
<th>REQUIRED</th>
<th>Strongly Recommended</th>
<th>Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus/Diphtheria/Pertussis (Td/Tdap):</td>
<td>Varicella</td>
<td>Hepatitis B/Hepatitis A and B Combined</td>
</tr>
<tr>
<td>MM / DD / YY (within the last 10 years)</td>
<td>1st Dose:</td>
<td>1st Dose:</td>
</tr>
<tr>
<td></td>
<td>2nd Dose:</td>
<td>2nd Dose:</td>
</tr>
<tr>
<td></td>
<td>MM / DD / YY</td>
<td>MM / DD / YY</td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td>3rd Dose:</td>
</tr>
<tr>
<td></td>
<td>Date of Illness:</td>
<td>MM / DD / YY</td>
</tr>
<tr>
<td>Polio (OPV/IPV)</td>
<td></td>
<td>MM / DD / YY</td>
</tr>
<tr>
<td>Series Completed:</td>
<td></td>
<td>MM / DD / YY</td>
</tr>
<tr>
<td></td>
<td>MM / DD / YY</td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps, Rubella (MMR)</td>
<td>Meningitis</td>
<td>Human Papillomavirus (HPV)</td>
</tr>
<tr>
<td>1st Dose:</td>
<td>Series Completed:</td>
<td>1st Dose:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2nd Dose:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3rd Dose:</td>
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<td>MM / DD / YY</td>
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<td></td>
<td>MM / DD / YY</td>
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<tr>
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<td></td>
<td>MM / DD / YY</td>
</tr>
<tr>
<td></td>
<td>MM / DD / YY</td>
<td>MM / DD / YY</td>
</tr>
</tbody>
</table>

TUBERCULOSIS SCREENING

If NO to questions 1, 2, and 3, PPD and X-ray are not required. (Reference source – http://apps.who.int/ghodata)

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.

2. Is the student a member of a high-risk group or entering the health professions? ☐ Yes ☐ No
   If NO, proceed to question 3.
   If YES, administer tuberculosis skin test and record results below (See A). 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. Record results below (See B).

3. Was the student born/has traveled (spent six or more weeks) in a country where TB is endemic? ☐ Yes ☐ No

DOCUMENT TUBERCULOSIS SKIN TESTING AND/OR CHEST RADIOGRAPHY (based on above criteria)

A. Tuberculin Skin Test (read 48 to 72 hours later)
   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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MARYMOUNT UNIVERSITY STUDENT HEALTH FORM

Name ___________________________ Student ID__________________ Date of Birth,___________

PAGE THREE
Must be completed by all undergraduate resident students and those graduate students who will reside in Marymount University housing, student athletes, and all Malek School of Health Professions students. It is to be completed by a physician or health care provider. The health care provider must SIGN the bottom of the page in order for the form to be validated.

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

<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEAD, EARS, NOSE and THROAT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RESPIRATORY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CARDIOVASCULAR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HERNIA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EYES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GENITOURINARY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MUSCULOSKELETAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>METABOLIC/ENDOCRINE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NEUROPSYCHIATRIC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SKIN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TEETH</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

Health Care Provider (SIGNATURE REQUIRED FOR VALIDATION)

_______________________________________________________________________________     __________________________________________________________________________________
Physician’s Name (Print) Physician’s Signature / Date
________________________________________________________________________________________ _____________________________________________________________________________
Address (Print)            Phone

MALEK SCHOOL OF HEALTH PROFESSIONS STUDENTS

The following signature of the Malek School of Health Professions student indicates that permission is granted for the submitted Student Health Form to be shared with the Malek School of Health Professions for clinical placement requirements.

Student Signature: ___________________________ Date: __/__/__

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