

# STUDENT MEDICAL FORM



**MARYMOUNT**  
UNIVERSITY

## 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](http://www.marymount.edu/Student-Life/Health-Wellness/Student-Health-Center), or by visiting [www.uhcr.com/marymountu](http://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.





## MARYMOUNT UNIVERSITY STUDENT HEALTH CENTER

2807 N Glebe Road ♦ Berg 1014 ♦ Arlington, VA 22207

Phone (703) 284-1610 ♦ Fax (703) 284-3816 ♦ Email shc@marymount.edu

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

Last name:		First name:		Student ID:	
U.S. Address:				<input type="checkbox"/> Resident <input type="checkbox"/> Commuter	
City:			State:		Zip Code:
Date of Birth:		Home Phone:		Cell Phone:	

### 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	Croatia	Kazakhstan	Nepal	South Africa
Algeria	Democratic People's Republic of Korea	Kenya	Nicaragua	Sri Lanka
Angola	Democratic Republic of the Congo	Kirabati	Niger	Sudan
Argentina	Djibouti	Kuwait	Nigeria	Suriname
Armenia	Domincan Republic	Kyrgyzstan	Pakistan	Swaziland
Azerbaijan	Ecuador	Lao People's Democratic Republic	Palau	Syrian Arab Republic
Bahrain	El Salvador	Latvia	Panama	Tajikistan
Bangladesh	Equatorial Guinea	Lesoto	Papua New Guinea	Thailand
Belarus	Eritrea	Liberia	Paraguay	The Former Yugoslav Republic of Macedonia
Belize	Estonia	Libyan Arab Jamahiraya	Peru	Timore-Leste
Benin	Ethiopia	Lithuania	Philippines	Togo
Bhutan	Fiji	Madagascar	Poland	Tunisia
Bolivia	Gabon	Malawi	Portugal	Turkey
Bosnia and Herzegovina	Gambia	Malaysia	Qatar	Turkmenistan
Botswana	Georgia	Maldives	Republic of Korea	Tuvalu
Brazil	Ghana	Mali	Republic of Moldova	Uganda
Brunei Darussalam	Guam	Marshall Islands	Romania	Ukraine
Bulgaria	Guatemala	Mauritania	Russian Federation	United Republic of Tanzania
Burkina Faso	Guinea	Mauritius	Rwanda	Uruguay
Burundi	Guinea-Bissau	Mexico	Saint Vincent and the Grenadines	Uzbekistan
Cambodia	Guyana	Micronesia (Federated States of)	Sao Tome and Principles	Vanuatu
Cameroon	Haiti	Mongolia	Senegal	Venezuala (The Bolivian Republic of)
Cape Verde	Honduras	Morocco	Seychelles	
Central African Republic	India	Mozambique	Sierra Leone	Viet Nam
Chad	Indonesia	Myanmar	Singapore	Yemen
China	Iraq	Namibia	Solomon Islands	Zambia
Columbia	Japan		Somalia	Zimbabwe
Comoros				
Congo				
Cote d'Ivoire				

STUDENT LAST NAME

STUDENT FIRST NAME

DATE OF BIRTH

**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)**

**Skin Test:**

1. Date Placed: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ 2. Date Read: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ 3. Result: \_\_\_\_\_ mm  
*Please record actual mm of induration, transverse diameter; if no induration, write "0"*

**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.

A new chest x-ray is not required if patient is currently undergoing or has completed LTBI treatment.

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-Diphtheria:** 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

STUDENT LAST NAME

STUDENT FIRST NAME

DATE OF BIRTH

**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

Hepatitis B  
 Twinrix

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: \_\_\_\_/\_\_\_\_/\_\_\_\_ Administred 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

**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 OR  Cervanix

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

1) Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

2) Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Part 8: HEALTHCARE PROVIDE 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 by 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 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

\_\_\_\_\_  
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 anytime. I have chosen not to be vaccinated against meningococcal disease.*

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
If student is a minor, signature of parent/guardian

\_\_\_\_\_  
Date



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