

UNIVERSITY OF MOUNT UNION STUDENT HEALTH RECORD

Last name _____ First Name _____ MI _____ Preferred Name _____

Home Address _____ City _____ State _____ Zip Code _____

Date of Birth _____ Biological Sex M _____ F _____ Gender Identity _____ Preferred Pronoun _____

Student's Cell Phone _____ Social Security # _____

EMERGENCY CONTACT: _____ Relationship _____

Home Phone _____ Cell Phone _____ Work Phone _____

INSURANCE INFORMATION **PLEASE ATTACH A COPY FRONT AND BACK OF INSURANCE CARD

Insurance Company _____

Address _____

Member ID _____ Group # _____

Primary Card Holder's Name _____ Primary Member's Date of Birth _____

Primary Card Holder's relationship to student _____

OPERATION OF THE STUDENT HEALTH CENTER

The Student Health Center of the University of Mount Union is operated and the medical services rendered pursuant to a Student Health Services Agreement between the University of Mount Union ("UMU") and Aultman Alliance Community Hospital and Alliance Community Medical Foundation, (collectively "Aultman"). The Student Health Center is located in facilities owned by Aultman but leased by UMU. The students of UMU are entitled to request and receive medical services at the Student Health Center.

INDEMNITY AND HOLD HARMLESS

As provided hereinabove, all operations and the providing of medical services at the Student Health Center of the University of Mount Union will be performed by employees and agents and at the direction of Aultman. The University of Mount Union is providing access to healthcare solely for the benefit of its students. As a result, by execution of the within Agreement by Student and/or Parent of Student ("Beneficiaries"), the Beneficiaries do hereby agree to release the University of Mount Union from any claim arising out of medical services provided to the Student by Aultman and agrees to indemnify, hold harmless and defend the University of Mount Union from any and all claim, demand or cause of action whatsoever arising out of or in any way related to the providing of services or the operation of the Student Health Center of the University of Mount Union operated by Aultman.

CONFIDENTIALITY STATEMENT

All information on these pages is considered confidential and protected. The information on these pages and all medical information entered into the record of the student at the Student Health Center are entered into and maintained in the Aultman Electronic Medical Record ("EMR"), an electronic system owned, maintained and operated by Aultman. All information on these pages and all medical information regarding the student and medical treatment of the student will be maintained in confidence pursuant to the protections and regulations of the Health Insurance Portability and Accountability Act (HIPAA). Medical information will not be released to anyone, including parents, unless the student signs a separate release of information specific to each illness/incident.

STATEMENT OF AUTHORIZATION

Authorization is hereby granted, for the health and welfare of the student, for the Physician or Physician Assistant to admit him/her to the hospital if necessary, and to refer this student to any duly licensed physician or surgeon when indicated. Permission is given to administer any medication, treatment, vaccines, etc., deemed necessary by the Student Health Center staff and/or Aultman.

Signature of Student _____ Date _____

Date _____

***Signature of Parent/Guardian (if student under age 18)

UNIVERSITY OF MOUNT UNION STUDENT HEALTH RECORD

STUDENT NAME _____ DATE OF BIRTH _____

Student's Medical History – Provide date and explanation for any “YES” answers

Have you ever had.....	Y	N	DATE	EXPLANATION
Migraines or Frequent/Severe Headaches				
Seizures				
Cancer or other immune disorder				
Diabetes/other endocrine disorder (thyroid)				
Mononucleosis				
Blood Disorder				
AIDS/HIV				
Asthma				
Seasonal Allergies				
Tuberculosis				
High Blood Pressure				
Heart Murmur/Heart Disorder				
Gastrointestinal Disorder				
Hernia				
Kidney Disease				
Hepatitis or other Liver Disease				
Menstrual Irregularities				
Genetic Disorder				
Anxiety				
Depression				
Other Mental Health Disorder				
Physical Disability				
Orthopedic Problems				
Substance Abuse				
Any other Condition/Illness				
Are you allergic to medication or latex?				
Other allergies?				
Do you take medication? Please list all				
History of surgeries				

Family Medical History (parent, grandparent, sibling)

Do any of your immediate relatives have or had...	Y	N	Relationship		Y	N	Relationship
Cancer				Seizure Disorder			
High Blood Pressure				Mental Health Disorder			
Sickle Cell Trait				Sudden Death (before 50)			
Lung Disease				Heart Disease			
Diabetes				Other			

I certify that, to the best of my knowledge, the information provided is complete and accurate.

Student Signature _____ Date _____

UNIVERSITY OF MOUNT UNION

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE (To be completed by ALL incoming students)

Name _____

Date of Birth _____

Have you ever had close contact with persons known or suspected to have active TB disease? YES____ NO____

Have you been a resident and/or employee of high-risk congregate settings (e.g., correction facilities, long-term care facilities, and homeless shelters)? YES____ NO____

Have you been a volunteer or health care worker who served clients who are at increased risk of active TB disease? YES____ NO____

Have you ever been a member of any of the following groups that may have an increased incidence of latent tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? YES____ NO____

Have you had frequent or prolonged visits to one of more of the countries or territories listed below with a high prevalence of TB disease? (If yes, please CHECK the countries or territories below) YES____ NO____

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country below) YES____ NO____

Afghanistan	China, Macao SAR	Honduras	Myanmar	South Africa
Algeria	Columbia	India	Namibia	South Sudan
Angola	Comoros	Indonesia	Nauru	Sri Lanka
Anguilla	Congo	Iraq	Nepal	Sudan
Argentina	Democratic People's	Kazakhstan	Nicaragua	Suriname
Armenia	Republic of Korea	Kenya	Niger	Tajikistan
Azerbaijan	Democratic Republic of the	Kiribati	Nigeria	Thailand
Bangladesh	Congo	Kuwait	Niue	Timor-Leste
Belarus	Djibouti	Kyrgyzstan	Northern Mariana Islands	Togo
Belize	Dominican Republic	Lao People's	Pakistan	Tokelau
Benin	Ecuador	Democratic Republic	Palau	Trinidad and Tobago
Bhutan	El Salvador	Latvia	Panama	Tunisia
Bolivia (Plurinational State	Equatorial Guinea	Lesotho	Papua New Guinea	Turkmenistan
Of)	Eritrea	Liberia	Paraguay	Tuvalu
Bosnia and Herzegovina	Eswatini	Libya	Peru	Uganda
Botswana	Ethiopia	Lithuania	Philippines	Ukraine
Brazil	Fiji	Madagascar	Portugal	United Republic of Tanzania
Brunei Darussalam	French Polynesia	Malawi	Qatar	Uruguay
Bulgaria	Gabon	Malaysia	Republic of Korea	Uzbekistan
Burkina Faso	Gambia	Maldives	Republic of Moldova	Vanuatu
Burundi	Georgia	Mali	Romania	Venezuela (Bolivarian
Cote d'Ivoire	Ghana	Marshall Islands	Russian Federation	Republic of)
Cabo Verde	Greenland	Mauritania	Rwanda	Viet Nam
Cambodia	Guam	Mexico	Sao Tome and Principe	Yemen
Cameroon	Guatemala	Micronesia (Federated	Senegal	Zambia
Central African Republic	Guinea	States of)	Sierra Leone	Zimbabwe
Chad	Guinea-Bissau	Mongolia	Singapore	
China	Guyana	Morocco	Solomon Islands	
China, Hong Kong SAR	Haiti	Mozambique	Somalia	

If the answer is **YES** to any of the above questions, University of Mount Union requires that you receive TB testing as soon as possible, but **at least prior to the start of the semester**.

TUBERCULIN (TB) SKIN TEST OR QUANTIFERON GOLD BLOOD TEST – ATTACH RESULTS

DATE _____ NEGATIVE _____ POSITIVE _____

****A positive TB test requires a chest x-ray ***Please attach results**

UNIVERSITY OF MOUNT UNION STUDENT HEALTH RECORD

Student's Name _____ Date of Birth _____

Please complete this form and include a copy of your immunization record. ****ALL IMMUNIZATIONS ARE HIGHLY RECOMMENDED, HOWEVER MANDATORY IMMUNIZATIONS ARE TWO DOSES OF MMR OR TITERS SHOWING IMMUNITY, AND A TDAP WITHIN THE LAST 10 YEARS.**

VACCINE	DOSE 1	DOSE 2	DOSE 3	DOSE 4	DOSE 5
Dtap Diphtheria, Tetanus Pertussis					
**Tdap (required within 10 years)					
**MMR – 2 doses Measles, mumps, rubella Required					
Varicella Chicken Pox					
Hepatitis B					
Hepatitis A					
Meningococcal					
HPV Human Papillomavirus					
Influenza Most recent					
IPV/OPV Polio					
COVID 19					

Statement of Exemption to Immunization: If you cannot complete the required vaccines, a waiver form must be returned to the Student Health Center. Note that students who have not been immunized may be excluded from class and residence halls if an outbreak of a vaccine preventable disease occurs on campus.

INFORMATION NEEDED FOR THE OFFICE OF RESIDENCE LIFE

In order to comply with an Ohio law, which went into effect July 1, 2005, any student planning on living on campus must be informed of the risk associated with and the benefits of vaccinations for meningitis and hepatitis B. In accordance with this law, we are providing you with the link to the Ohio Department of Health website (www.odh.ohio.gov) for further information.

Please note that this law does not require vaccination, nor does it require the institution to provide or pay for these vaccines. It requires only disclosure of whether or not you have been vaccinated. Your signature below will suffice as a release for the Student Health Center and Aultman to be able to share the information regarding only those immunizations with the office of Residence Life, should the need arise.

Signature _____ Date _____