EASTERN MENNONITE UNIVERSITY

EMU Health Evaluation

EMU Health Services
Phone: (540) 432-4317 Fax: (540) 432-4099

INSTRUCTIONS

- Please follow directions carefully and answer all questions. Health Services reserves the right to require a physical exam whenever indicated.
- **Please print neatly.**
- **Return completed form including immunization record to the EMU Health Services by August 1st for fall registration and December 5th for spring registration (or upon admission to graduate/seminary program). Failure to comply will result in a hold in your registration process for the following semester.**
- **Return this form immediately after completion to: EMU Health Services, 1200 Park Road, Harrisonburg, VA 22802 / fax to 540-432-4099**

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Name: ______________________________ **EMU ID#:** ______________
LAST/Family FIRST/Given SECOND/Additional

Home mailing address: ______________________ ______________, ______________
Number & Street/ Route & Box City State Zip Code

Home Phone: (____)______-________ **Cell phone:** (____)______-_______ **Age:** _____ **Date of Birth:** __________

Email Address: ________________________ **Birth Country:** ____________ ☐ Male ☐ Female **SS#:** _____-___-_____

Emergency contact: __________________________ **Relationship:** ____________ **Phone:** (____)________-__________

Health Care Provider: ____ **Phone:** (_____)_______-___________

Admitted to: CJP, MAC, Seminary, MBA, M.Ed., MA BioMedicine **(Please Circle One)**

Were you enrolled at EMU prior to this admission: ☐ yes ☐ no **Name during prior enrollment:** _______________

HEALTH INSURANCE INFORMATION

☐ I will be joining the EMU Student Health Plan. For information, go to www.bollingercolleges.com/emu
☐ I will not be joining the EMU Student Health Plan for the current academic year.
☐ I do not have health insurance.

Please complete all insurance information below.

Name of policy holder: ____

Name of insurance company or group: ____

Group / ID number: ____

Address / telephone number of company: _____________________________________

I fully understand that I am legally responsible for any medical expenses incurred during my enrollment at EMU. The health and insurance information on this form is correct, but should it change while I am a student at EMU, it is my responsibility to notify EMU Health Services.

Signature of student: ____ **Date:** __________________________

EASTERN MENNONITE UNIVERSITY
IMMUNIZATION RECORD

Name: ______________________________ ______________________________
Last Name First Name

EMU ID number: __________________ **Date of Birth:** ___/___/___
Month – Day – Year

You can request immunizations from:
Health care provider **Your local health department** **High school counseling office/Central Office**

Please have a health care provider complete this form and sign it at the bottom, OR have the health care provider fax your immunization records. NOTE: If immunization records are not available, blood titer reports are sufficient.

VACCINE	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	DATE OF TITER&RESULT (or disease)
DPT series					
Hepatitis B series (or sign Waiver)					
MMR – measles, mumps, rubella (not required if born before 1957)					
Meningitis – Menactra / Menomune (Circle one)					
Polio series OPV/IPV (circle one)					
TDAP (within 10 yrs.)					
Varicella - chicken pox-two vaccines required (if no history of disease or born after 1979)					

Tuberculosis Screening/Testing

Have you lived/traveled outside the U.S. for more than 3 months, within the past 5 years? ☐ **Yes** ☐ **No**

If yes, please list countries: ______________ ______________ ______________

(All students may receive screening/testing at the EMU Health Services.)

a. ☐Screening – Not high risk
b. ☐Blood test results Date _____/_____/_____ Positive / Negative
b. ☐PPD (Mantoux) Date Given_____/_____/_____ Date Read_____/_____/_____
Result _____ mm induration (horizontal diameter)
c. ☐Attach report of chest x-ray if positive for blood test or ppd
☐ INH Prophylaxis: Dates: From ____/____/____ To ____/____/____

Health Care Provider: ______________________________ ____________________ **Date** ____________
Signature/Title **Phone Number**

Health Care Provider: ______________________________ ____________________
PRINT NAME **Fax Number**

Meningitis Waiver

I have read the meningococcal disease and immunization information from the Virginia Department of Health website http://www.vdh.state.va.us/Epidemiology/factsheets/Meningococcal.htm and the CDC vaccine information sheet at: http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-mening.pdf . I have chosen not to be vaccinated.

______________________ ______________________ ____________
Signature of Student Printed Name Date

Hepatitis B Waiver

I have read the hepatitis B disease and immunization information from the Virginia Department of Health website http://www.vdh.state.va.us/Epidemiology/factsheets/Hepatitis_B.htm and the CDC vaccine information sheet at: http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-hep-b.pdf . I have chosen not to be vaccinated.

______________________ ______________________ ____________
Signature of Student Printed Name Date