EMU Grad Student Health Information Form

EMU Health Services 1200 Park Rd., Harrisonburg, VA 22802
Phone: (540) 432-4308;
Upload **completed** form at: https://emu.medicatconnect.com/

INSTRUCTIONS

- Please follow directions carefully and answer all questions. Health Services reserves the right to require a physical exam whenever indicated.
- **Please print neatly.**
- **Please scan and upload your COMPLETED Form (*no blank pages please)* to https://emu.medicatconnect.com/**
- **If unable to upload electronically, please return COMPLETED form including immunization record to EMU Health Services by mailing or emailing by *August 1st for fall registration* and *December 5th for spring registration* (or upon admission to graduate/seminary program). Failure to comply will result with a hold in your registration process for the following semester.**

Admitted to: (Please Circle One) CJP; Counseling; Seminary; MBA; M.Ed.; MA; MSBioMedicine; MSN; Other _____

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

Local mailing address:_____, _____
Number & Street/ Route & Box City State Zip Code

Home Phone: (____)____-_____ **Cell phone:** (_____)____-_____ **Age:**_____ **Date of Birth**(mm/dd/yyyy): _____

Birth Country: _____ **Pronoun:** _____ **SS#:**_____

Emergency contact:_____ **Relationship:** _____ **Phone:** (___)_____-_____

Health Care Provider: _____ **Phone:** (_____)_____-_____

Were you enrolled at EMU prior to this admission: ☐ yes ☐ no

Name during prior enrollment:_____ **Departure date/year of prior enrollment:** _____

HEALTH INSURANCE INFORMATION

- **Please complete page 3 of this form and upload a copy of the front and back of your insurance card.**

Personal/Family History:

Have you or any of your family ever had any of the following illnesses? If yes, please give relationship, i.e. self, mother, father, uncle, etc.

Asthma	Cancer – type:
Depression/anxiety/other	Diabetes
Heart disease	High blood pressure
Kidney disease	Tuberculosis
Any chronic illness not mentioned	Sudden death before age 50

Allergies (drug, food, etc.) _____

Hospitalizations/Surgeries (reasons & dates) _____

Current medications taken regularly _____

I fully understand that I am legally responsible for any medical expenses incurred during my enrollment at EMU. It is my responsibility to notify EMU Health Services of health/insurance changes while enrolled. By signing below I authorize release of pertinent medical information and future medical consultations with relevant EMU Departments knowing that all medical information will be kept confidential.

Signature of student:_____ **Date:** _____

EMU IMMUNIZATION RECORD

Name: _____ _____
Last Name First Name

EMU ID number: _____ **Date of Birth (mm/dd/yyyy):**___/___/___

- **You can request immunizations from:**

  Health care provider Your local health dept. Undergrad. College/Univ. High School/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.**

TB screening at a U.S. facility -Required****

TB Screening date – Must be within one year of current enrollment: ___/___/_ RESULT: Positive / Negative
IF TB Screening is POSITIVE, complete a, b, and/or c below.

a. PPD (Mantoux) Date Given____/____/____ Date Read____/____/____ Result_____mm induration (horizontal diameter)

b. IGRA blood test results (T-Spot, Quantiferon Gold) -- Positive / Negative -- Date____/____/____
c. Chest x-ray - if positive IGRA blood test or ppd (attach x-ray report)
☐ INH Prophylaxis: Dates: From____/____/____ To____/____/____ OR ☐ Sign waiver for INH Therapy

VACCINE	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	DATE OF TITER&RESULT
Hep A (2 doses) Hep AB (Twinrix -3 doses)					
Hepatitis B series					
MMR – measles, mumps, rubella **(not required if born before 1957)**					
Meningococcal – one must be given at age 16 or older (or sign Waiver)					
Polio series OPV/IPV (circle one)	Last date of series				
TDAP / TD (within 10 yrs.)					
Varicella - chicken pox (or year of disease; not required if born before 1980)			**Date of disease:**		

Health Care Provider:_____ _____ **Date** _____
Signature/Title **Phone Number**

Health Care Provider: _____ _____
PRINT NAME **Fax Number**

If you wish to sign a waiver for any other vaccines please go to https://emu.edu/studentlife/health/docs/vaccine-waiver.pdf - and follow the instructions.

_____ _____ _____
Signature of Student Printed Name Date

EMU HEALTH INSURANCE INFORMATION

Student's Name:_____ Date of Birth:_____ EMU ID: _____

- **ATTACH** a legible copy of the front & back of your current insurance card (if covered on multiple plans, please indicate which insurance is **PRIMARY** and which is **SECONDARY** coverage).
- It is recommended for students to keep a copy of their insurance card with them at all times.
- Check with your insurance provider to see what kind of health care coverage you have while attending Eastern Mennonite University (i.e. out of state, out of network, etc.).
- **Provide updated information** to EMU Health Services if you have insurance coverage changes while enrolled at EMU to prevent delays/denials with claims.
- EMU Health Services **does not accept Medicare**.

Please check all that apply to you currently:

_____ I have **enrolled** for EMU Health insurance coverage.

_____ I have **private** health insurance; i.e. Aetna, Blue Cross/Blue Shield, Cigna, Kaiser, Optima, United, etc.

Name of Insurance Company: _____

_____ I have **Medicaid** coverage. If yes:_____VA Medicaid _____Out-of-state Medicaid
NOTE: **Virginia Medicaid is the only Medicaid accepted by EMU Health Services.**

_____ I do not have health insurance and expect to pay the "Self-pay" charge at the time of service.

Patient Insurance Authorization:

I hereby authorize EMU to furnish information to insurance carriers concerning my illness, condition, and treatment, and I hereby irrevocably assign to EMU Health Services all payments for medical services rendered to myself or my dependents. I understand that I am financially responsible for all charges that may be charged to my student health account.

_____ _____
Signature of Patient Date

_____ _____
Name of Policyholder/Subscriber Policyholder/Subscriber's Birthdate